Maternal and Child Health Services
Title V Block Grant

State Narrative for Utah

Application for 2009
Annual Report for 2007

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.
An attachment is included in this section.

C. Assurances and Certifications

The Utah Department of Health has submitted the Assurances and Certifications to the authorized signatory and has on file the signed Assurances and Certifications dated July 9, 2007. The State Title V Office has on file a copy of the Assurances and Certifications -non-construction program, debarment and suspension, drug free work place, lobbying program fraud, and tobacco smoke. They are available at any time for review upon request. The state Title V agency is compliant with all the federal regulations governing the Title V funding allocated to Utah.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

The Maternal and Child Health (MCH) bureau announced to the public that the Utah Department of Health, Division of Community and Family Health Services is responsible for administration of the MCH Block Grant received by the State of Utah under the provisions of Title V of the federal Social Security Act. It was explained that in this capacity, the Division is required annually to submit an application to the U.S. Department of Health and Human Services. Public notices published in major newspapers throughout the state made it known that the proposed annual program activities related to annual goals for the Fiscal Year 2009 MCH Block Grant Application were available for public review and comment. Special email requests for input and feedback were made to specific stakeholders including: parents, consumers, health care providers, academia, community-based advocacy organizations, local health departments, community health centers and members of advisory groups.

Written copies of the proposed program activities were made available by contacting the Utah Department of Health and were also posted on-line at the following internet site: http://health.utah.gov/mch/mchblock.html. The website directed the user to the 2009 Annual Goals web page which outlined the proposed activities for each goal. The user was able to provide feedback on-line.

Additionally, a request for public comment was posted on the Utah Department of Health (UDOH) intranet, which is available to approximately 1,300 employees. Both written comments and on-line comments were accepted between April 25 and May 18, 2008. The input received was shared with the core program staff responsible for individual National and State Performance Measures to consider for incorporation in the final 2009 Annual Plan. Comments were incorporated into the plan as appropriate.

Public input was received on 22 of the 27 National and State Performance Measures (82%). During the weeks when the proposed annual program activities related to performance measures for the Fiscal Year 2009 MCH Block Grant Application were available on-line for public review and comment, the MCH Block Grant, 2009 Annual Goals and Public Comments web pages accounted for almost 40% of UDOH website visits.

The Utah MCH bureau also has a regular mechanism in place to obtain input and feedback on Reproductive Health Program activities through the Perinatal Task Force. This task force meets quarterly and acquires stakeholder participation in how to address critical perinatal health issues such as insurance access, interpregnancy intervals, very low birth weight outside tertiary care , preconception health, birth control usage, weight gain during pregnancy, unintended pregnancy, HIV / STI / perinatal infections, Hispanic infant mortality, and domestic violence. Members of this public task force provide ideas, comments, and strategize program efforts and activities.

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

Utah performs well in overall health measures like quality, access and patient safety. Those measures put Utah in the top eight states according to a new report by the Department of Health & Human Services' Agency for Healthcare Research and Quality (AHRQ). Utah is the only state among 30 Southern and Western states to receive a "Strong" rating by the AHRQ. A closer look, however, points to areas where improvement is still needed, including the number of uninsured, immunization rates and providing needed care for children with chronic health conditions. When compared to the nation, Utah hospital, patient safety in obstetric injuries and home care measures were rated above average. Utah also did well in residents' use of lower-cost generic drugs and showed a lower median charge for hospital admissions than neighboring states. Utah has improved in its ranking for adequacy of prenatal care and immunizations.

Although the economic picture in Utah is very strong with increasing state revenues and the lowest unemployment rate in the state's history, Utah offers the least of any state at $1712.00 per year per capita in public assistance according to a recent study conducted by the Urban Institute. Utah has a three-year limit on TANF eligibility compared to five years in most other states. ***/2009/ Utah's economy has taken a downward turn, however, not to the same degree as other states. Utah's unemployment rate remains lower than the national rate. //2009//***

Utah faces a number of health care system challenges. The rate of uninsured has increased over the past two years. ***/2009/ over the past several years//2009//*** Utah's eligibility criteria for Medicaid and CHIP are more stringent than in other states. Governor Huntsman has made uninsured children a state priority and has pushed the state legislators to increase state funding for the CHIP program, separate from Medicaid. The 2007 Legislature did increase state funding for CHIP which allowed the program to once again open enrollment on July 2, 2007. ***/2009/ The 2008 Legislature appropriated enough funding to CHIP to enable the program to remain open continuously. //2009//*** More than 17% of women of childbearing ages (17.2%) had no insurance in 2006, a large increase from 10.8% in 2001. The uninsured rate among Hispanic women is even higher. Utah's disproportionate age distribution with a higher proportion of children compared to national figures (32% v. 26%) poses challenges to access to services for health care among others due to a lower tax base than in other states. ***/2009/ The state is currently working to develop a health care reform package to address the growing population of individuals without insurance. //2009//***

Obviously, the health care system is currently not fully able to address the needs of some MCH populations, given that Utah was ranked 48th among the 50 states and District of Columbia for the number of "Child Health MDs" per 100,000 children (55.7 vs. the national average of 85) and 40th for general pediatricians (40 vs. 57.5) per 100,000. The same trend is noted for obstetricians and gynecologists in the state. There are vast areas of the state without any specialty provider.

Almost 9% of children were unable to get needed medical, dental, or mental health care in the previous 12 months, and that 28.1% of children had no regular medical checkup. Utah has an 11.0% prevalence of CYSHCN. The proportion of Utah children rated as overweight and obese has increased along with the rest of the nation. Chlamydia rates are increasing, suicide ideation and attempts are increasing among Utah adolescents. ***/2009/ Utah's teen pregnancy rate has increased following the national trend. //2009//***

We have made progress in promoting mental health of children and postpartum mothers. We

work to increase awareness of the relationship between physical and mental health, to promote screening for social emotional delays and postpartum depression, to establish linkages with key partners on a state and local level and to provide trainings as appropriate. ***/2009/ The state is submitting an application for a SAMHSA grant to address early childhood wellness that will integrate mental health services in a number of pediatric practices. The state ECCS grant will focus on early childhood mental health as this is an area of greatest need in the "system" of services for young children and their families. //2009//***

We are currently focusing on mental health, prevention of obesity, immunizations, preconception health and transition of CYSHCN. Given the growth in minority and ethnic populations in the state, Title V is working closely with the Department's Center for Multicultural Health to identify needs and develop strategies to address the needs of specific populations.

Strengths that we have identified are the Governor's commitment to reducing the rate of uninsured children, strong infrastructure, strong data analytic capacity along with a demonstrated commitment to use the data we collect, strong Title V infrastructure, and strong partnerships, among others. Challenges include funding limitations, rural and frontier health care access, especially specialty providers, and the high proportion of children to adults which leads to low tax base to support the high demand for services. ***/2009/ Because of federal cuts in the Title V grant, we are forced now to not fill positions when staff leave. For example, the MCH Bureau has lost at least two positions this past year due to budget shortfalls. The positions, unfortunately are important ones, a child health and school nurse consultant position as well as a data analyst position. Loss of these positions leaves the Department with no capacity to support school nurses in the state or to provide nursing consultation for child health, and also reduces our data capacity. //2009//***

/2009/ Another strength for Utah is the Governor's commitment to global warming and environmental concerns. As of August 2008, state agencies will operate four days per week from 7 a.m. to 6 p.m. in order to save energy costs to the state and to reduce gasoline consumption by one day commute for those staff who drive to work. //2009//

III. State Overview

A. Overview

Utah is largely a rural and frontier state, with the majority of the state's population residing along the Wasatch Front, a 75-mile strip running from Ogden (north) to Provo (south) with Salt Lake City, the state's Capitol, in between. The Wasatch Front comprises only 4% of the state's landmass, but 76% of the state's population resides here. The rest of the population (24%) resides in the remaining 94% of the state's land mass comprised of rural areas of more than six, but less than 100 persons per square mile and frontier areas of less than six persons per square mile. Five percent of the state's population lives in the frontier area (70% of the land mass), and 19% lives in the rural portion (26% of the land mass).

Utah is the fifth fastest growing state in the nation. /2008/ sixth //2008// Utah's population estimate for 2003 was 2,351,467, a 5.3% increase from the 2000 Census compared to 3.3% for the nation. /2008/ as of 2005, population was 2,490,334, a 11.5% increase compared to 5.3% nationally //2008// Utah experienced a 29.6% population increase from the 1990 to the 2000 Census. According to the Governor's Office of Planning and Budget estimates, by the year 2010, Utah's population will grow to 2.8 million.

While Utah is predominately white, ethnic minorities now make up a larger portion of the state's population, comprising 16.2% of the state's total population compared to 14.6% five years ago. /2008/ 16.4% //2008// In 2003, the population of every racial and ethnic group, except White (both Hispanic and non-Hispanic), grew at a higher rate than the state. /2008/ 2005 -- except white and American Indian/Alaskan Native. //2008// During 2000 to 2003, among the five race categories, the highest growth rate occurred among the Black population (16.6%), followed by Asian (15.5%), Native Hawaiian and Pacific Islander (10.1%), American Indian/Alaskan Native (7.2%), and White (4.9%). /2008/ Black population (17.6%), followed by Asian (16.1%), Native Hawaiian and Pacific Islander (9.7%), White (8.9%), and American Indian/Alaskan Native (4.8%). //2008// In 2003, Hispanics accounted for 10% of state's total population, a 15.8% increase since 2000. /2008/ 2005 -- 10.9%, a 31% increase //2008// Refugee populations in Utah are growing, along with the Hispanic populations, with resultant increasing need for language translation services. These factors impact the health care system's ability to adequately address the needs of the diverse populations.

Utah continues to have the youngest population in the nation with a median age of 27.7 years. /2008/ 28.5 //2008// The American Community Survey Summary indicated that 32% of the Utah population was under the age of 18 years in 2003. /2008/ in 2005 -- 31.2% //2008// For 2002, Utah had the highest birth and fertility rates in the nation at 21.2 and 90.6 compared to 13.9 and 64.8 for the nation. /2008/ 2004 -- 21.2 and 92.3 compared to 14.0 and 66.3 //2008// For many years Utahns have had larger households compared to the nation. In 2003, Utah's household size was 3.07 compared to the national average of 2.61. /2008/ 2005 -- 2.60 //2008// Utah's average family size was 3.55 compared to the national average of 3.19. /2008/ Utah -3.56 national -3.18 //2008// The percent of Utah family households with children is 30% higher than the rest of the nation, 42.0% versus 32.2%. /2008/ 25% higher. 43.6% versus 34.9% //2008// Households comprised of single mothers with children are lower in Utah than the nation, (5.7% vs. 7.6%). /2008/ 5.6% vs 7.6% //2008// Utah Hispanic household size was larger than the U.S. Hispanic household size (3.9 vs. 3.5.) /2008/ 3.5 vs. 3.4 //2008// Utah's median household income was somewhat higher than that of the U.S. However, Utah's households are also larger with a significantly lower per capita income in Utah than in the U.S. overall. Based on the 2003 American Community Survey Summary, Utah's median household income of $52,481 was slightly higher than the U.S. average of $52,273, ranking Utah 15th nationwide. /2008/ 2005 - $47,934 (2005 inflation adjusted dollars) US - $46,242, ranking Utah 18th //2008// Due to larger families in Utah, the per capita income ranked the state 45th in the nation at $18,905. /2008/ 40th in the nation at $20,814 //2008//

/2009/ Utah's population median age for 2006 was 28.4 years compared to the national

median age of 36.4 years. Two areas in Utah have median ages below the state median, these are Cache County at 24.6 years and Utah County at 29.6 years. These two communities have universities located in their county, so the median age difference can be attributed to a larger population of young students and their children. Cache County has the highest fertility rate at 115 versus the state at 83 versus the U.S. rate of 55. //2009//

/2009/ Utah's child population is relatively healthy when compared to national data as noted in the 2003 Survey of Children's Health. Almost 90% of Utah children are reported to heave excellent or very good overall health status; 70.4% of children are reported to have excellent or very good teeth; lower percentage of children with overweight BMI, in spite of a much lower percentage of children who exercised vigorously. Areas in which Utah scored lower than the national rate were children having preventive medical visits, both medical and dental preventive care visits, and having received all needed medical care. //2009//

Based on the 2005 American Community Survey, Utah had a significantly higher percentage of high school graduates at 90.1% versus 84.2% nationally among individuals 25 years and older. Utah's population is similar to the nation for percent of the population with a bachelor's degree or higher degree (27.9% in Utah compared to 27.2% of the U.S. population). Even though the proportion of Bachelor's degree and higher education achievement was comparable, Utah has a higher percentage of individuals with some college but no degree at 26.9% compared to 20.1% nationally. The high school drop out rate in Utah is not as high as the U.S. at 7.1% of youth ages 16 to 19 years old versus 9.5% at the national level. ***/2009/ Data from the 2006 survey indicate that Utah ranks second in the country for high school graduation at 90.2% compared to the national rate of 84.1%. //2009//***

The National Center for Education Statistics identified Utah with the lowest funding per elementary and secondary student during 2004 to 2005 at $5,216. The national average was $8,701 per student with the District of Columbia spending the most at $13,348 per student. /2008/ Fortunately, the 2007 Utah Legislature approved an increase in teachers' salaries. The Governor is very committed to education in Utah and supports a number of initiatives, such as all day kindergarten, pre-k programs and more funding for teachers and schools. //2008// ***/2009/ In addition the student to teacher ratio is 26.1 students per teacher compared to the national ratio of 15.3 students per teacher. Utah classrooms in general have at least 10 more students per teacher than in classrooms across the nation. The Governor signed a Proclamation in April 2007 creating the Child and Family Cabinet Council. The Council is composed of heads of state departments that provide services to children and families as well as community leaders. The Council is developing strategies to promote the education and safety for children and families. From the Cabinet Council, the Early Childhood Commission has evolved, formerly known as the Early Childhood Committee. The Early Childhood Commission is headed by the Governor's Deputy of Education and is focusing on early childhood educating, pre-K and all day Kindergarten (kindergarten in Utah is not mandatory). The state Title V Director sits on the Commission to represent the health and wellness perspective for young children and their families in this effort. //2009//***

Utah's predominant religion counsels against the use of tobacco and alcohol which consequently results in a lower incidence of diseases associated with abuse of these substances, such as liver disease, alcoholism, and lung cancer. Utahns pride themselves on family values and support many efforts to improve maternal and child health. The political environment is conservative with a fairly large group of individuals who hold anti-government philosophies that at times make it difficult to obtain state funding for state agency programs.

Based on the Utah Health Status Survey (UHSS), 11.6% of Utah's population reported no health insurance in 2005, a steady increase from 9.1% in 2003 and 8.7% in 2001. ***/2009/ The uninsured population in Utah has grown to 11.9% of the population reporting no insurance. //2009//*** The proportion of uninsured has increased in the maternal and child

populations as well. In 2005, 8.5% of children under age 18 were uninsured compared to 8.2% in 2004 and 7.3% in 2003. Of females ages 18- 44, 15.3% reported no health insurance in 2005 compared to 14.8% in 2004. More than a third (37.35%) of the Hispanic population reported no insurance in the 2005 UHSS. The steadily climbing rates of uninsured individuals in the state especially children and women of childbearing ages, is very concerning. The Governor sponsored a state summit in 2005 to discuss issues related to a state plan to address the increasing rates. ***/2009/ The Governor and the state legislature are leading an effort to develop a health care reform package to address the growing population of uninsured. //2009//***

Utah's median household income was somewhat higher than that of the U.S. However, Utah's households are also larger with a significantly lower per capita income in Utah than in the U.S. overall. Based on the 2003 American Community Survey Summary, Utah's median household income of $52,481 was slightly higher than the U.S. average of $52,273, ranking Utah 15th nationwide. Due to larger families in Utah, the per capita income ranked the state 45th in the nation at $18,905. ***/2009/ Utah's median income was $51,309/ ranking the state 19th and above the national average of $48,451. Utah's poverty rate is well below the national average, ranking the state 12th in the nation. In 2006, Utah's poverty rate was 10.6% compared to 13.3% nationally. Utah's child poverty rate is fifth lowest at 11.9% compared to the national rate of 18.3%. //2009//***

The geographic distribution of the state's population presents significant challenges for accessing health care services for those living in the rural and frontier areas as well as for delivery of health care services. In the rural and frontier areas, many residents are not able to readily access health care services due to long travel distances and lack of nearby hospital facilities and health care providers, especially specialists. Specialists are not available to rural/frontier residents except by traveling hundreds of miles. In addition residents living in the rural/frontier areas may be reluctant, if not unwilling, to utilize certain services in their communities, such as family planning or mental health, because of concern for confidentiality and anonymity in seeking these services in a very small town.

Of particular concern is meeting health care needs of Hispanics due to the increasing number without documentation. These families are more difficult to reach due to language barriers; cultural beliefs about preventive health care; transportation constraints; and ineligibility for many government programs. Prenatal care for women without documentation is a problem since they are not eligible for public assistance, even though their newborns will be citizens and eligible for benefits. ***/2009/ The Reproductive Health Program participated in a qualitative data project of the Center for Multi-cultural Health to obtain data from Hispanic women to better understand their health issues. The Center is finishing a report on a number of health issues of various subpopulations in the state. These data will be helpful in the Department's work to identify key health issues for specific subpopulations and to develop more effective methods to reach populations we currently aren't reaching well.//2009//***

Utah Title V programs have worked to promote increasing awareness of the Department of Justice regulation announced in 1999 that assures families that enrolling in Medicaid or the Children's Health Insurance Program will not affect immigration status. While programs, such as the Covering Kids and Families Utah Project, have promoted this information, many families remain skeptical about applying for any government programs for fear they will be reported to the U.S. Citizenship and Immigration Services or that their immigration status will be affected. This fear and distrust of government agencies has been compounded by The U.S. Citizenship and Immigration Services (formerly INS) recent raids on Utah businesses with a large undocumented worker population resulting in deportation of the workers. /2008/ In addition, the 2006 and 2007 Utah Legislatures debated bills restricting undocumented immigrants from obtaining a drivers license, in-state college tuition, and state funded programs and so on. The bills on drivers license, state funded programs and in-state college tuition all passed. The sentiment is not supportive of undocumented workers in the state. ICE has conducted a number of raids of businesses looking

for undocumented workers with the result of families being torn apart, leaving some children without any parent to care for them. //2008// ***/2009/ Raids on Utah businesses have escalated this past year, with hundreds of undocumented workers being arrested and deported, leaving many children without a mother or father or both parents. //2009//***

Maternal and child health services, including services for children and youth with special health care needs, are provided in various settings: through medical homes/private providers; local health departments, community health centers, a clinic for the homeless, migrant health clinics, and several free clinics; itinerant clinics offered through the CSHCN Bureau to rural communities without specialty providers; and, specialty centers, such as the University of Utah Health Sciences Center, Primary Children's Medical Center, and Shriners Hospital for Children, and several tertiary centers for high risk perinatal and neonatal care. These centers of excellence provide centralized specialty and subspecialty services to pregnant women, infants and children with high-risk pregnancies, neonatal intensive care, and numerous disabling conditions, such as asthma, hemophilia, cystic fibrosis, diabetes, Down syndrome, cancer and orthopedic disorders. Although this allows for better coordination of care because there are fewer providers, it also presents a problem of service delivery to high-risk mothers and infants, and special needs children in rural Utah. CSHCN provides direct services in their Salt Lake City office for three specific populations: follow-up of premature infants, developmentally delayed preschool aged children and developmentally/behaviorally disorder school aged children and youth.

Utah's public health system consists of 12 autonomous local health departments (LHDs). Six of the 12 local health departments are multi-county districts and cover large geographic areas. Many districts include both rural and frontier areas within the service region. Many local health departments are gradually moving away from direct services, recognizing that they do not have the capacity to provide primary care for those living in their communities. Each local health department determines which services they provide for mothers and children in their district. ***/2009/ In the past few years, we have required the local agencies to conduct an assessment of health care needs for mothers and children. Local agencies were provided a template for the local needs assessment, including data to be obtained and reviewed, capacity assessment, and a template for identifying top priorities and plans for addressing the priorities. While some districts were reluctant to engage in the process, many found it to be helpful. When you do the same thing for years, sometimes it is difficult to step back and look at what you are doing versus what your needs are. This process helped local health departments to reassess the services they offer and approaches they use. //2009//***

Services available through LHDs vary district by district. For example, direct prenatal services are no longer available through LHDs, although two districts provide clinic space and support staff for pregnant women served by University of Utah Health Sciences Center providers and Family Practice Residents. Family planning services are available through mid-level practitioners in only a few health district clinics. The shift away from direct services provided by LHDs reflects the changing public health system to focus more on core public health functions, including health promotion and prevention services.

The ten community health centers throughout the state and the Wasatch Homeless Clinic in Salt Lake City provide primary care to underinsured and uninsured MCH populations. Seven of the ten community health centers are located in rural areas of the state. Two mobile Utah Farm Worker clinics operated under Salt Lake Community Health Centers, Inc. are co-located with Wasatch Front community health centers in Provo and Ogden with a third mobile clinic in Enterprise, Utah. Utah Farm Worker Program's permanent site is located in Brigham City, in Northern Utah. Unfortunately, many of Utah's Hispanic workers, especially along the Wasatch Front, are not engaged in farm work and therefore do not qualify for these services.

Since 1995 Medicaid participants living in Utah's urban counties have been required to enroll in a managed health plan. This requirement is the Choice of Health Care Delivery Program, which is allowed under a federally approved freedom-of-choice waiver. In FY05 the Utah Department of

Health's Division of Health Care Financing (HCF), Utah's Medicaid agency, contracted with two managed health plans and one PPO to provide services to Medicaid participants, including children with special health care needs, in Utah's urban counties. In the past, HCF had contracts with four managed care organizations, but health plans struggled financially to continue delivering services to the Medicaid population. One health plan continues to expand into rural areas of the state providing an option for Medicaid participants in most areas of the state. At the present time enrollment for rural Medicaid participants is voluntary, allowing them the option of choosing either fee-for-service, a primary care provider or a health plan if available in their area. Medicaid participants in all but three rural counties are enrolled in a Prepaid Mental Health Plan for behavioral health services.

The hospital health care system for MCH populations is well developed in Utah, with five large tertiary perinatal centers and three tertiary children's hospitals. ***/2009/ Now Utah has six tertiary care perinatal centers. //2009//*** Our definition of a tertiary perinatal center includes both perinatology and neonatology on staff. Although the Guidelines for Perinatal Care define levels of perinatal care by neonatal care capacity, we include the level of obstetrical care as well based on the relationship between the mother's care and the infant's care. All but one of the perinatal centers has University of Utah Health Sciences faculty assigned and are well recognized throughout the state and the Intermountain West as a consultation and referral center for obstetrical and pediatric providers. The centers work with hospitals within their referral areas to encourage consultation and referral as needed, depending on the condition of the mother, infant or child. In 2004, St. Mark's Hospital in Salt Lake City, which had employed neonatologists in the past, hired a maternal-fetal medicine specialist, qualifying the hospital as Utah's fifth tertiary perinatal center.

CFHS staff interfaces with faculty and staff from these centers through various efforts, including Perinatal Mortality Review, Child Fatality Review, Perinatal Taskforce, Perinatal HIV Taskforce, clinical services, joint projects, and other committee work. Through these efforts, the need and importance for consultation and referrals between levels of service are emphasized via reports of mortality review findings, or reports on specific topics, such as low birth weight.

Utah, not unlike other areas of the country, suffers from a shortage of certain types of health care providers in different geographic areas, including nurses, neonatologists, dentists, mental health professionals, etc. Provider shortages exist throughout the state. The Health Professional Shortage Area (HPSA) maps detail areas of the state with provider shortages for medical, dental and mental health providers. Access to dentists in Utah is a major issue, particularly for Medicaid participants and for individuals living in rural/frontier areas of the state. The University of Utah Health Sciences Center is currently working on a proposal for a dental school, however, local dentists by and large do not support the efforts. Mental health providers, especially those specializing in children's mental health, are limited, in part due to the mental health system in the state which is a Medicaid carve-out serving primarily the chronically mentally ill, but not necessarily those with acute conditions. /2008/ A dental workforce survey is being conducted at present that will help identify gaps in access in the state. Urban areas also experience shortages of certain types of health care providers, such as nurses, pediatric neurology, genetics, developmental pediatrics and primary care providers who care for adults with special health care needs as they have transitioned from their pediatric providers. //2008//

Access to maternal and child health care varies depending on the geographic area of the state. According to Health Professional Shortage Area surveys conducted between 2000 and 2004, some areas in Utah have high ratios of women of childbearing ages to providers, resulting in limited access to a reproductive health provider in their area. Women in rural communities may have to travel many miles to a provider's office and/or hospital. More than half of the counties (16 out of 29) are without any obstetrician-gynecologist with several counties reporting as few as 1 provider to 10,000 women of childbearing age, creating a need to assure better access to consultation services for rural providers.

Even where prenatal care providers are more numerous, under-and uninsured women may be confronted with caps on the number of women an agency is able to accommodate including Presumptive Eligibility determination. However, gaps exist in some areas of the state due to specific geographic situations, such as Wendover, uniquely located in two states with different rules and regulations governing federal and state programs.

Since the income eligibility level for Utah's Prenatal Medicaid program has not been increased from 133% of the FPL since its beginning in 1990, many women and their families, best categorized as working poor, are ineligible for health care coverage, making it difficult for them to access health care, especially prenatal and family planning services. Medicaid's current eligibility level for children birth to 5 years is 133% FPL and 100% FPL for children 6 -18 years of age. Both the prenatal and the children's programs require an asset test for eligibility determination. The asset limit prohibits many families that otherwise would qualify for the program from being eligible. Bills have been proposed in the recent Legislative Sessions to remove the asset test without success.

Utah CHIP Program began in 1999 with an income eligibility of 200% of the FPL for children from birth to 18 years. The Program has suffered from budgetary limitations and has had to cap enrollment to stay within its budget. Additional funding in the 2004 and 2005 Legislative Sessions has enabled the program to increase enrollment numbers and maintain open enrollment. However the increases did not keep up with the need for insurance. /2008/ The 2007 Legislature approved an additional $4 million to enable the program to once again open enrollment to applications on July 2, 2007. It is not known if this latest increase in the funding allocation will meet the demand for health coverage for all eligible children, either for Medicaid or CHIP. //2008// ***/2009/ The 2008 State Legislature authorized additional funding for the CHIP Program and has designated it as a state entitlement program. //2009//***

Presumptive eligibility for prenatal Medicaid has been problematic in some areas of the state, especially in the urban areas with limited Presumptive Eligibility (PE) sites. To increase access to PE along the Wasatch Front, application via phone was instituted 2001 enabling over 2,000 women annually to apply by this method. /2008/ now almost 3,000 women //2008//. Co-location of PE workers and Medicaid eligibility workers has also assisted women in accessing Medicaid eligibility faster. For the occasional situation where the waiting times for appointments are too long, women are referred directly to the Department of Workforce Services workers to make a direct Medicaid application. Pregnant clients ineligible for PE or Medicaid and unable to afford private care are referred to one of two University of Utah Health Sciences Center prenatal clinics located in local health departments or to one of six community health centers located along the Wasatch Front offering sliding fee schedules. ***/2009/ During the past year, the Department of Health eligibility workers were moved to the Department of Workforce Services to consolidate all edibility workers in one Department. While this may improve efficiency, some advocates have expressed concern because it has been perceived that Department of Health workers were more customer service oriented than the Department of Workforce Services workers. //2009//***

Access to low-cost maternal and child health care services provided by community health centers is problematic in several areas of the state since they are not located in many rural areas. Fortunately in the past couple of years, three new community health centers have opened in the more rural areas of the state. The Association for Utah Community Health, the state's primary care association, works to promote development of new or expansions of existing community health centers in Utah. /2008/ Free clinics have formed to help address the needs of the uninsured population. //2008//

Other areas of the state where access to low-cost health care services is problematic include: Tooele County, especially the Wendover area; Wasatch and Summit Counties; Bear River Health District; TriCounty Health District; and portions of Central and Southeastern Utah Health Districts Native American Indian women and their children in Southeastern Utah may have to travel to

Tuba City, Arizona for services if they wish Indian Health Service to pay for their care. While the local health departments in all of these areas receive Title V funds, demand for services far outstrip the amount of funding available.

The Child Health Evaluation and Care (CHEC) Program, Utah's Early and Periodic Screening, Diagnosis and Treatment Program, provides coverage for a variety of services for Medicaid-covered children that are recommended by the American Academy of Pediatrics. The guidelines for the CHEC Program are very similar to the AAP recommendations. The Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ) found that services and quality varied among small groups of pediatric practices that were engaged in quality improvement processes. These practices served children enrolled in Medicaid and children with private insurance.

In 2006, Medicaid changed policy to allow reimbursement to pediatric providers for fluoride varnish applications for eligible children. The service has not been widespread to date, but some pediatric practices are considering providing the service.

Most specialty and sub-specialty pediatric providers are located along the Wasatch Front, including the state's tertiary pediatric care centers, Primary Children's Medical Center and Shriners Hospital for Children. The location of most pediatric specialists and sub-specialists in the most populous area of the state presents a problem for provider access for special needs children in rural Utah. In several counties of Utah, there are no pediatricians or sub-specialists, necessitating families to drive long distances to access care for their children. In most cases, there is only limited additional itinerant coverage from the private sector for this large geographic area. In rural counties, health care is often provided to children through family practice physicians, local health departments or community health centers.

Title V programs across the nation are working toward the six CSHCN core components of: 1) family/professional partnership at all levels of decision-making; 2) access to comprehensive health and related services through the medical home; 3) early and continuous screening, evaluation and diagnosis; 4) adequate public and/or private financing of needed services; 5) organization of community services so that families can use them easily; and 6) successful transition to all aspects of adult heath care, work and independence. Over the past 5 years, numerous successful public and private projects have expanded and improved the service system for Utah CYSHCN and families at both the state and community level. Despite significant changes and improvements in the system, gaps in services and needs remain as evidenced by data from surveys and reports from parents and providers.

Although components of Utah's system of care have greatly improved for families, the system itself has become increasingly complex, especially in the areas of funding, insurance coverage and the increasing number of Utah residents who are culturally or linguistically diverse. Utah has seen a series of funding cuts over the past 5 years, affecting health, educational and social services across the state. Though Utah has the highest birth rate in the nation and a rapidly growing population, there has been no appreciable increase in the availability of specialty pediatric services over the past several years. Families continue to face formidable barriers in accessing services and coordinating care for their CYSHCN.

The CSHCN Bureau is addressing these issues through the many initiatives, some of which include the Medical Home Initiative and MedHome Portal website, Telehealth, traveling multidisciplinary clinics, the Fostering Healthy Children Program, community based case management teams, Baby Watch/Early Intervention and collaboration with Family Voices and the Utah Leadership Education in Neurodevelopmental Disabilities (ULEND) grant. These initiatives are described in greater detail later in this document.

The current financial situation in Utah is good as we have a very strong economy and a very low unemployment rate. However, the challenge to the state Title V agency is that there are few state dollars for services for mothers, children and adolescents, including those with special health care

needs and their families. With modest cost of living increases, stretching federal dollars becomes harder each year. Local health departments are also struggling to provide services with funding allocations that don't increase making it hard for them to meet the cost of living increases. The changing economy is resulting in less flexibility with dollars than in previous years. State staff is sensitive to the impact that state budget cuts have on local agencies as well, and often will preserve the allocation of federal contract dollars to local agencies by eliminating state level funding. Competition for funding is becoming a matter of carefully balancing what exists with current need, consideration of how the dollars will have the most impact. State level needs, as well as local level needs, may be sacrificed during a time of economic downturn. As an example, ongoing discussions at combined CDC and HRSA Early Hearing Detection and Intervention (EHDI) meetings have suggested the possibility that HRSA EHDI funds could be rolled into the MCH Block Grant. Requiring states to cover previously funded programs (in this case the identification of newborns with hearing loss) through the MCH Block Grant could create additional financial obstacles particularly when the required outcome has been legislatively mandated by the state. ***/2009/ While Utah is not suffering the degree of economic turn down that other states are experiencing, we are feeling the impact of decreases in projected revenues. The decrease in the Title V Block Grant over the past several years and the fact that the funding has not even kept up with inflation rates over a number of years results in challenges to us to continue to provide the services that we have in the past. Examples include loss of staff positions, loss of content areas, such as SIDS and school nurse consultation. //2009//***

Documenting disparities at times is difficult given small numbers of populations in which to draw significance. The Department has endeavored to include data on subpopulations in the state in an attempt to better quantify the issues faced by various groups of individuals. The 2004 Legislature appropriated funding for the Center for Multicultural Health, which was supplemented in the 2005 and 2006 Legislative Sessions with additional funding. The Center is housed in the Division of Community and Family Health Services and assists the Department of Health in identifying priorities and needs of specific key populations in the state, updating an Ethnic Health Report, assessing the adequacy of ethnic data from common public health data sources and recommending improvements, inform ethnic communities about the Center's efforts and activities, and developing guidelines for cultural effectiveness for UDOH programs. The Center plays an important role in bridging the needs of ethnic communities in Utah and the work of the Department of Health and its partners in addressing these needs. The Center works closely with Title V programs to identify ways in which we can work more closely together on MCH needs. Staff work with a community-based organization Communidadas Unitas to improve the health of Latinas. ***/2009/ Currently the Center is gathering information to publish "fact sheets" to outline key health issues for each specific minority population. This approach will highlight the significant health problems for each population rather than by disease or health problem. The three Bureaus in the Division have designated at least one staff member who oversees MCH and CSHCN efforts in regard to multi-cultural activities and materials. The Center for Multi-Cultural Health has provided cultural competence training for both state and local public health staff. The Center is in the process now of identifying key health issues of each of the subpopulations living in the state. The Center will develop "fact sheets" for each subpopulation that addresses key health needs so that the specific needs of a population are highlighted rather than approaching health issues for minority groups by disease categories. These fact sheets will better enable staff to focus efforts on the key health needs of each specific subpopulation. //2009//***

In addition, the Department has a staff person designated as the Liaison to the Native American communities in the state, which is helpful to programs attempting to address the unique needs of the Native American populations.

The health care system in Utah is developing more cultural awareness, especially as the population of Utah changes. The results of a 1997 Department of Health qualitative study of ethnic populations indicated that individuals of ethnic populations feel as though they were

inadequately or poorly treated because of their ethnicity; they wanted health care providers of their own ethnicity or providers who could relate to them and their beliefs; they want health care providers to ask them what they need and not assume what they need; they had to wait long times while others who arrived later were seen earlier; they need access to interpreters and materials in own languages; they want acceptance of their beliefs about health and prevention (one doesn't go to doctor if not sick); and, they want providers to be sensitive to gender issues. The Department plans on conducting another qualitative survey of ethnic populations in the state to determine current priorities.

The Division has built capacity for data analysis through the Data Resources Program. The Program has staff assigned to each of the three populations served by Title V programs. The Department has also built data capacity by forming the Center for Health Data which includes Vital Records and Statistics, survey data collection capacity (BRFSS, YRBSS, etc.), development of an Internet-based query system for health data (http://ibis.health.utah.gov/) that provides access to 120 different indicators and access to data sets, such as birth and death files, BRFSS, PRAMS, YRBSS, Utah Health Status Survey, hospital and emergency department data, population estimates, and Cancer Registry. The Center for Health Data provides access to large data sets for analysis by Department staff (and others outside the Department as appropriate), and works with programs in the Department to assist in data analysis as needed. Medicaid has developed a data warehouse for Medicaid data that is used by Title V to link with vital records data to track outcomes for Medicaid participants. /2008/ Access to WIC data has not been possible due to a rollout of a new Windows-based system that basically failed miserably. The system has undergone multiple reprogramming to make it usable. It now is functioning pretty well, but it is unknown at this time when we will be able to access WIC data. //2008//

The Data Resources Program includes a data analyst assigned to CSHCN. The expansion of capacity has greatly facilitated access to data, as well as data quality and use of data for program planning efforts. The Program coordinates the MCH Epidemiology workgroup that includes representatives of the MCH programs to discuss data needs, projects and policy. /2008/ During 2007, the Data Resources Program formed another working group, the MCH Bureau data group, to discuss data projects and ideas focused only on the MCH populations. Staff from each of the five other MCH programs (WIC, Immunizations, Oral Health, Reproductive Health and the Child Adolescent and School Health programs) participates in these meetings. The meetings provide a forum for setting priorities, developing concepts of a data study, and so on. They enable the six programs' staff to learn what the others are doing or would like to do and are able to contribute ideas to each other's projects. //2008// ***/2009/ CSHCN has joined this group which will lead to improved awareness of available data bases and to encourage more active research efforts within CSHCN programs. The data capacity for MCH is pretty strong, but we need to build the capacity for programs in CSHCN. //2009//***

State statutes relevant to Title V program authority and their impact on the Title V program The Title V agency has authority under Statutory Regulatory Authority: Utah Code Ann. 26-1-18; 2610-1,2, 4, 7. This statute outlines the authority of the state agency in provision of Title V services for Utah's population, in developing a state plan for maternal and child health services, including those with chronic health problems. The Division of Community and Family Health Services is the designated state Title V agency is responsible for meeting the federal Title V requirements.

The Utah Administrative Code provides access to medical records for public health surveillance activities, which allows the UDOH to utilize medical records for a variety of programs including the Perinatal Mortality Review Program to review maternal, infant and fetal deaths to identify public health issues amenable to prevention.

Hearing, Speech and Vision Services serves as the coordinator and central registry for State mandated newborn hearing screening under Utah's Newborn Hearing Screening Act, 26-10-6, 1998 General Session, Title 26, amended by Chapter 162. The database serves as the Utah

registry for permanent hearing loss.

In 1965, statute (Section 26-10-6) was passed requiring that every newborn in Utah be tested for the presence of phenylketonuria (PKU) and other metabolic diseases, which may result in mental retardation or brain damage. In January 2006, newborn screening will be expanded to include 32 new tests; therefore the rule for this statute will be updated. The Newborn Screening Program provides tracking and follow up of abnormal screens and diagnostic testing, and provides education to institutions of birth, medical home (providers), and families. ***/2009/ In January 2009, the Newborn Screening Program plans to begin screening for Cystic Fibrosis. The rule for this statute has been updated so the Department may go ahead with these plans. //2009//***

Related legislation or statutes, which impact Utah's Title V programs, include the ongoing challenge of addressing the needs of minors relative to sexuality and prevention of pregnancy, STDs, and HIV/AIDS. Current state law prohibits any government agency, including local health departments, from providing contraceptive information or services to minors without parental consent. The optimal situation is, obviously, parental involvement and the Utah Department of Health has worked, largely through the Title V-funded Abstinence-only Education Program, to promote increased parental knowledge, skills and abilities to discuss sexuality issues with their children in their homes.

State law requires state agencies and political subdivisions of the state (local health departments) to obtain written parental consent prior to provision of family planning information or services to unmarried minors (unless the unmarried minor is a Medicaid recipient). This requirement can present a significant barrier to providing family planning services to adolescents. During the 2001 Legislative Session, Utah legislators passed a bill prohibiting the state from applying for CDC funding related to HIV/AIDS Education due to misunderstanding of CDC requirements for use of the funding. This legislation limits the state's ability to promote reduced risk for HIV/AIDS among its student populations. The impact of this mandate has resulted in the loss of YRBS funding as well. The political climate regarding CDC funding is unfortunately so controversial that the State Office of Education has not sought federal funding to continue YRBS Surveillance. The Utah Department of Health now funds and coordinates this survey in collaboration with the State Office of Education and with support for data analysis by CDC. This change has resulted in the Division of Community and Family Health Services reallocating funding to support the YRBS process and analysis.

Oversight of sex education curriculum approval in the state was moved from the State Office of Education to the local school district. This shift in oversight may in fact result in a less rigorous review than might occur at the State Office of Education level. Educational funding was changed to school district block grants for certain funding components allowing school districts to determine allocation of the funds. Included in the block granting was school nursing, raising a concern that school districts will prioritize other issues higher than school nursing. /2008/ The 2007 Legislature appropriated $1 million to the State Office of Education to enhance school nursing in the state. At this point, it is not known what the impact of the additional funding will have on the school nurse -- student ratio. //2008// ***/2009/ Problems with reauthorization of the Section 530 funding to states has created numerous problems for state programs. We are continuously updating our funded programs that the funding is on continuing resolution and appropriated a quarter at a time. Because this has been the case for several quarters, we are contemplating not continuing to receive the funds. We do not believe it is fair to the programs to continue to operate from quarter to quarter. It involves numerous contract amendments which is burdensome on state program staff and state financial and contract staff. //2009//***

In March 2002, Secretary of Health and Human Services, Tommy Thompson, signed Utah's Primary Care Network (PCN), which had been approved by the 2002 Utah Legislature. Approximately 25,000 adults with incomes between 100% -150% of FPL without insurance will be able to qualify and enroll for preventive health services under this plan. PCN will enable women

who are enrolled in prenatal Medicaid to continue preventive health care coverage for primary preventive care, including family planning services if desired.

Violence and Injury Prevention Program's statutory authority derives from the Utah Department of Health's (UDOH) responsibility for health promotion and risk reduction as defined in the Utah Code 26-7-1: "The department shall identify the major risk factors contributing to injury, sickness, death, and disability within the state and where it determines that a need exists, educate the public regarding these risk factors, and the department may establish programs to reduce or eliminate these factors."

The UDOH has also been empowered to "establish and operate programs necessary or desirable for the promotion or protection of the public health . . . or which may be necessary to ameliorate the major cause of injury." The local health departments also have authority to "conduct studies to identify injury problems, establish injury control systems, develop standards for the correction and prevention of future occurrences, and provide public information and instruction to special high risk groups".

During the 2005 Legislative Session, a number of bills were passed that impact maternal and child health care in the state, such as increasing the CHIP budget by $3.3 million, adding additional funding for the Center for Multicultural Health in the DOH, legalizing the practice of lay midwifery, including administration of some medications, with requirements for training. Bills that did not pass that impact health care included removing the asset test for pregnant women and children for Medicaid eligibility determination, and increasing dentists' reimbursement rates. Medicaid provider inflation increases were approved. /2008/ As mentioned previously funding for Medicaid, CHIP, the Center for Multicultural Health has received increased funding since the 2005 session. //2008//

/2009/ Each program that addresses the health of mothers and children has a specific program plan that identifies goals, objectives and activities. The process of strategic planning for each program varies from program to program. The Reproductive Health Program has developed a plan based on the National and State Performance Measures and the one state Outcome Measure. Each staff member is assigned responsibility for one or more measures. For example, the state outcome measure is maternal mortality which is addressed through the Perinatal Mortality Review process. The program works closely with vital records to obtain death certificates of women of childbearing ages matched to birth and fetal death records to identify as many maternal deaths that may have been related to a pregnancy. The review process involves review of medical records to determine if the death could have been prevented. We use the expanded definition of maternal mortality using a 12 month time frame and search for deaths that may not be specifically recorded as pregnancy related. For other programs, each is assigned responsibility for the related National and State Performance Measures in their program plans. Additional goals and objectives are developed by each program as issues arise, such as dental services for pregnant women is incorporated in the Oral Health Program plan. Generally each program holds a program staff retreat to review the previous year's accomplishments, strategies and needs. Based on these discussions, program managers amend program plans as needed. The annual report and application process provides an opportunity for each program to review its accomplishments and to amend their program plan as needed based on its achievement of the assigned measures. //2009//

An attachment is included in this section.

B. Agency Capacity

Dr. George Delavan, as the state Title V Director, is responsible for administration of the state Title V Block Grant. He accomplishes the administration of the Division through three Bureaus, all of which include programs funded through Title V or targeted to mothers, children or children with

special health care needs. The state agency administers the Title V Block Grant through Department allocations of funding to programs, as well as through contracts with local health departments, community health centers, academic institutions and community agencies. Through this five year needs assessment and identification of the state priorities for mothers, children and children and youth with special health care needs, Dr. Delavan met with Bureau Directors, key staff, and advocates to determine how the state can best address the identified priorities, both through new state performance measures, planned activities and strategies to address the new state performance measures and reallocation of funding or resources to ensure that the priorities are addressed through appropriate planning and resource allocation. The details on the plans for the state priorities are included in the section on plans for state performance measures.

The Division of Community and Family Health Services consists of three Bureaus: Bureau of Children with Special Health Care Needs, the Bureau of Health Promotion, and the Bureau of Maternal and Child Health.

The Bureau of Children with Special Health Care Needs consists of nine programs and is involved in the development of a system of care for CSHCN and their families throughout the state through infrastructure building, population screening, enabling access to services and providing direct services. The Bureau provides direct services for CYSHCN through its clinics at the UDOH, satellite clinics and itinerant clinics. The Bureau also works closely with primary care providers to ensure care is coordinated. The programs in the Bureau: Newborn Blood Screening; Hearing, Speech and Vision Services; Baby Watch Early Intervention; Child Development Clinic; Neonatal Follow up Program; Pregnancy RiskLine; Adaptive Behavior and Learning Environment Clinic; Fostering Healthy Children; and the Technology Dependent Waiver Program. Other major initiatives and grants include: Medical Home and Transition; Birth Defects Surveillance; Genetics Implementation Grant; the Child Health Advanced Record Management (CHARM) initiative; itinerant multidisciplinary and specialty clinics throughout the rural areas of the state; collaboration with the Utah Leadership Education in Neurodevelopmental Disabilities Grant (ULEND); Early Hearing Detection and Intervention Grants; SSI outreach, information, and referral and transition to adulthood for youth with special needs. Many of these programs provide direct services to children and youth with special health care needs and their families. These programs are funded through several funding streams including state funds, Title V funds, Title XIX funds and various grants from HRSA and CDC.

The Bureau of Health Promotion consists of eleven programs, which work to promote health and wellness. The main areas covered by this Bureau include Tobacco, Cancer, Heart Disease and Stroke Prevention, Diabetes, Asthma, Arthritis, and Violence and Injury Prevention. Many of these programs develop strategies to address needs of the mothers, children and their families, such a youth tobacco prevention, youth suicide, promoting healthy lifestyles among elementary school children through nutrition and physical activity, to name a few. Funding of these programs includes state funds, Title V, Preventive Block, CDC and HRSA grant funds.

The MCH Bureau includes six programs: Reproductive Health, Child Adolescent and School Health, Immunizations, WIC, Oral Health, and Data Resources. The Reproductive Health, Child Adolescent and School Health, Oral Health and Data Resources programs are funded with Title V funding, while Immunizations and WIC are funded with CDC and USDA funding respectively

The Data Resources Program has expanded capacity to address data needs of MCH and CSHCN programs to include a data analyst assigned to CSHCN and another dedicated to two programs, WIC and Immunizations. The latter position is jointly funded with USDA WIC Program and CDC Immunization Program funds, making for a strong partnership between the two programs. This expansion of capacity has greatly facilitated not only access to data, but also data quality and use of data for program planning efforts. The Program coordinates the MCH Epidemiology Network workgroup that includes representatives of the MCH programs to discuss data needs, projects and policy. We do not feel we are yet at full capacity at this time, but are hopeful we will be able to find additional funding to support greater capacity with data resources.

/2009/ With budget cuts, we have had to reduce one FTE in the Data Resources Program which reduces our data capacity. //2009//

State capacity to promote and protect the health of all mothers and children, including CYSHCN Utah's Title V staff continually identifies areas and populations to seek out underserved MCH individuals in order to prioritize allocation of programs and resources. These on-going needs assessment activities aid us in determining the importance of competing factors upon the health service delivery environment in the State. Staff then develops plans, identifies resources, and develops interventions to help support the needed MCH services. After a standard review of all the necessary structures that need to be in place to support the delivery of health services to the MCH population, the important health status measures are evaluated and the resources are directed toward those populations. ***/2009/ Unfortunately with budget cuts and salary adjustments for COLAs, Title V funds are getting extremely tight. As a result, positions that are vacated by staff leaving are not being filled. We have lost at least two positions in the MCH Bureau due to attrition, as well as four other positions in the Children with Special Health Care Needs Bureau. These reductions in positions really reduces our capacity to address issues like school nursing, etc. //2009//***

The staff also uses their expertise to identify and weigh those competing factors, which may limit the degree of accessibility or availability of MCH services across the state. This work is done in conjunction with other community organizations and individuals who are interested in this effort largely through the input from the CSHCN Executive Committee and the leadership in the MCH Bureau and that of the Bureau of Health Promotion. as well as staff involvement in various other committees, such as the Early Childhood Council, Covering Kids and Families Utah Project, etc. that raise issues of service need for MCH populations. Staff evaluates need and work toward refocusing efforts and resources as appropriate and available. //2008// Earlier in 2007, we decided to disband the larger MCH Advisory Committee and ask members to participate in the three subcommittees, mothers and infants, children and adolescents, and children and youth with special health care needs. These subcommittees are the groups that do the work associated with input to the block grant and our activities. The larger group meetings were not well attended, thus we decided to support the subcommittees for input, advice, and feedback. //2008// ***/2009/ As we start developing plans for the 2010 needs assessment, we will reconstruct the MCH/CSHCN Advisory Committee with new faces and representatives of agencies to ensure we get a broad range of input into the needs assessment process as well as input on key issues impacting the health and wellness of mothers, children and youth, including those with special health care needs, and families. //2009//***

Satisfaction surveys of program participants are conducted annually by some programs, such as the VFC program, which surveys VFC providers to get input on the program, and WIC, which conducts an annual survey of participants to provide input on the program. The survey results are reviewed by program staff to refine program processes to provide better service.

Division program staff review and analyze data related to MCH populations and produce reports, fact sheets, abstracts for conferences and submit articles for publication. Several articles have been published in peer review journals, which have included Division staff as one or more of the authors of the publication. Utah staff usually submits one to three abstracts for the MCH Epidemiology Conference every year and often have the abstracts accepted for publication. As issues or concerns arise regarding health outcomes or access to health services, staff reviews the literature and conduct additional analysis to gain more understanding of the factors associated with the issue. For example, since Utah ranks low among states for adequate prenatal care, staff have analyzed birth certificate data, PRAMS data, and conducted focus groups to identify barriers to early entry. Once this analysis was completed, a strategy to address the barriers was developed and implemented. The "13 by 13" campaign was launched to promote the importance of getting into prenatal care by the 13th week and to get at least 13 prenatal care visits (assuming a term pregnancy). The campaign has been evaluated as to its effectiveness in getting more women into early prenatal care. Results indicate that more than 45% of survey

respondents indicated that the spots did motivate them to get into prenatal care (PNC) and more than 40% said that the spots made them think about getting financial help for prenatal care. Two-thirds of women with late prenatal care indicated they needed help paying for prenatal care. And most importantly, the statewide adequacy of prenatal care increased to 78.8% in 2004.

The Department of Health has been integrally involved in a state-level coalition targeted to early childhood systems development, the Early Childhood Council (ECC). The ECC is an evolution of an earlier committee that had been meeting for a number of years around systems development for early childhood services. The Council includes representation of the state agencies that provide services to this population of children, service providers, and advocacy organizations. The ECC has been restructured to conduct business more effectively. The Steering Committee of the ECC is the advisory group over the federal State Early Childhood Comprehensive Systems Grant, which can facilitate the work needed to support the ECC and its goals to a certain extent. ***/2009/ The ECC has been transferred over to the Governor's new Early Childhood Commission. Much of the ECC work on the infrastructure for early care and education will be promoted through the work of the Commission. The focus of the state ECCS grant will shift primarily to mental health and wellness as this is an area that is not a primary focus of the Commission. In addition, we are applying for a SAMHSA grant for early childhood wellness with a plan to integrate mental health into primary care practices. //2009//***

The Oral Health Program coordinates with the Utah Dental Association and the Utah Dental Hygienists Association to secure volunteers for activities like Sealant Saturdays and Head Start dental examinations. We are very fortunate to have the State Dental Director housed in the Division within the Maternal and Child Health Bureau. The Dental Director has worked hard to establish a strong collaborative relationship with the Utah Dental Association, local health departments and community health centers, local dental societies and advocacy organizations. He has been very successful in engaging the Association leadership in oral health promotion and advocacy activities. Oral health is on the Department's radar screen relative to the importance of oral health and general health and the need to ensure that services are accessible.

The state Title V Director, George Delavan, is representing the Title V agency on the Steering Committee for the collaborative effort sponsored by the Intermountain Pediatric Society, Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ) to improve health care to children with quality improvement (QI) efforts in pediatric practices. UPIQ partners with the IPS, the Utah Chapter of the American Academy of Pediatrics, include the University of Utah Department of Pediatrics, Intermountain Healthcare (formerly known as IHC), HealthInsight, Title V and Medicaid. The quality improvement process is achieved through Learning Collaboratives that bring practice teams together to lean the basics of QI principles and developing a plan to apply the process in the practices throughout a twelve-month period of time with support via conference calls, personal visits, materials, and so on.

The Bureau of Maternal and Child Health maintains contracts for MCH/CSHCN services with each of the 12 autonomous local health departments. The Department has been encouraging a shift in local health department service from direct service provision to a refocus on the core public health functions. The MCH Bureau is promoting this refocusing of public health efforts with the local health departments by changing the contracts with the LHDs to require a local needs assessment, which includes a review of the local data for the MCH Performance and Outcome Measures, local capacity assessment, and prioritization of health care needs in MCH populations in their district. The expectation is that each local health department will work with its partners in the community to help determine local capacity, identify gaps and health needs of the MCH populations to then identify priority needs in the local district. The local health department staff and its partners then will review current services to determine if they correspond to the identified needs. The local health department may need to adjust resources, staff, programs, and funding to better address the identified needs in their communities if not reflected in the current service delivery. During FY06, all health departments will operate under the new contract requirements. Local health departments provide services for mothers, women of childbearing ages and for

children, including those with special health care needs. These services include direct services as well as enabling and population-based services.

/2009/ Local health departments provide services for mothers, women of childbearing ages and for children, including those with special health care needs. These services include direct services as well as enabling and population-based services. Direct services include family planning, immunizations, dental care, fluoride varnish application for children in WIC and in schools; nurse home visiting; targeted case management (Medicaid); screening women for depression during pregnancy and postpartum; Enabling services include contacting families to ensure their children are receiving medical and dental preventive visits per Medicaid guidelines; referral to programs for eligibility determination, such as WIC, Medicaid, CHIP, and other services, such as Early Intervention, etc.; and providing immunization vouchers, car seats, and helmets Other services: Health education and promotion: In schools: dental sealants, abstinence education;; safety issues; General public: education regarding unintended pregnancies and closely spaced pregnancies, preterm labor signs and symptoms and prevention; car seats and bicycle helmet use; importance of early and continuous prenatal care, oral health, health and safety, and Back to Sleep. Child care consultation is offered by one of the local health departments. Strategies that local health departments have used to promote utilization of services include: co-locating with other services, such as dental clinics, and Medicaid eligibility workers; and, utilizing WIC visits for immunizations and other services. //2009//

State staff has provided data training and needs assessment process training and plans to provide technical assistance and consultation as needed by each of the local agencies. The local needs assessment process was modified from NACCHO's Making Strategic Decisions about Service Delivery: An Action Tool for Assessment and Transitioning. /2008/ Local health departments (LHDs) are now moving into the implementation phase of the process. The needs assessment and planning process were not well received by the local health departments, but recently it has become apparent that it is serving a valuable function as LHD Nursing Directors are now asking what to do if they want to work on a different priority than the ones they identified and worked on initially. //2008// ***/2009/ The state applied for a small grant from AMCHP for program evaluation training, mainly for CSHCN programs. The training was open to staff from the two other Bureaus as well as other interested Department staff. The training was very well attended and those participating reported that the training was helpful in doing their work. //2009//***

MCH and CSHCN Bureau staff participates in compliance and quality monitoring of Medicaid managed care organizations (MCOs), including periodic site visits to assess reproductive health services for women, EPSDT services and services for children with special health care needs. This process includes a review of the MCO's quality improvement plan, HEDIS data and other documentation as it relates to services for pregnant and postpartum women, children with special health care needs, and EPSDT services. Medicaid MCO contracts include the requirement of a satisfaction survey for special needs populations. CSHCN Bureau staff has been involved with the planning of two surveys completed in the past three years. The first Consumer Assessment of Health Plans Survey (CAHPS) survey sample was Medicaid disabled category children. Results were favorable and parents were generally satisfied with the availability of care and quality of services received through the MCOs, including specialty services. The initial CAHPS survey has been revised with the additional questions, but data are not yet available. CSHCN staff participates on Medicaid's Utilization Review and CHEC/EPSDT Expanded Services Committee, which meet twice a month to determine coverage of non-covered services for Medicaid recipients, with the former CSHCN Bureau Director, and the Bureau pediatric physical therapist having voting status. /2008/ The CSHCN Bureau Director and Medical Director serve on Medicaid committees and assist Medicaid with issues related to children with special needs. However, Medicaid has discontinued its request for Title V staff to assess the HMO's MCH services. //2008// ***/2009/ The CSHCN Medical Director serves on the CHEC Committee as well. //2009//***

Local school nurses work collaboratively with school district special education departments in a variety of activities, such as developing health care plans for children with special health care needs. School nurses provide the training and education to staff regarding special needs children and may designate responsibility for providing certain health services as appropriate under the current Nurse Practice Act and accompanying rules. Funding and staffing shortages contribute to the shortage of school nurses across the state. ***/2009/ One of the positions lost due to budget shortfalls has been the school nurse consultant. Currently we have no one fulfilling that role which is unfortunate, especially as the state legislature mandates medication administration in the schools, such as glucagon, epi-pens, and so forth. //2009//***

The Division collaborates with many other programs and agencies in and outside the Department of Health to improve services for mothers, children and children and youth with special health care needs. The Division is involved in a variety of coalitions, task forces, advisory committees that are sponsored by other programs, such as Medicaid, or other state agencies or community-based organizations. Some examples include: the Medical Care Advisory Committee (Medicaid); Child Care Licensing Advisory Committee (UDOH Bureau of Licensing); Child Abuse and Neglect Council (Department of Human Services); Covering Kids and Families Coalition (Voices for Utah Children); Utah Coalition to Promote Breastfeeding (WIC); Utah Perinatal Association, Utah Chapter of the March of Dimes, the Fetal Alcohol Syndrome Taskforce, Utah Chapter of National Family Voices, Oral Health Advisory Committee, Youth Suicide Prevention Task Force, Safe Kids Coalition, Utah's Transformation of Child and Adolescent Network (UT CAN --mental health and substance abuse), to name just a few. In addition, Title V has developed strong relationships and collaborations with faculty at University of Utah Health Science Center --Department of Pediatrics, Department of Obstetrics and Gynecology, Department of Psychiatry, Department of Family and Community Medicine; Utah State University --Early Intervention Research Institute (EIRI) and Center for People with Disabilities; Utah Parent Information and Training Center, Utah Department of Workforce Services, Office of Child Care, Department of Human Services, Division of Children and Families, Division of Substance Abuse and Mental Health; and, State Office of Education (USOE).

As part of the FY06-10 Needs Assessment process, the Title V Director and key MCH and CSHCN staff reviewed the elements of CAST-V to assess the Utah Title V agency's capacity needs. Overall Utah's Title V agency has much capacity and the elements that were noted as needing improvement really only reflect the desire to development these elements to a higher level. The elements are in place, but barrier may prevent staff from accomplishing as much as they would like. Overall, the agency has capacity for 21 of the 28 elements, with the remaining 7 elements needing improvement or further development. The seven elements included: 1) Authority and funding sufficient for functioning at the desired level of performance --the challenges in this element include: inability to create new positions to address capacity needs due to legislative restrictions; restrictions on applying for grant funds if new positions are needed to carryout the grant; and limited state funds for grants that require non-federal match. 2) Mechanisms for accountability and quality improvement --we have informal processes in place for quality improvement for many programs, but limited ability to implement quality improvement with contractors, such as local health departments. Programs providing direct services tend not to be receptive to quality improvement as it interferes with service provision. 3) Formal protocols and guidance for all aspects of assessment, planning and evaluation cycle --this element is one that we need to focus more on and develop staff capacity. 4) Adequate data infrastructure --We have strong data support, but capacity needs to be built to better support data needs of the state Title V agency in its work. 5) Other relevant state agencies --While the UDOH has strong collaborative relationships with many state agencies, the State Office of Education has been very difficult to engage in collaborative initiatives. With a new Executive Director, perhaps this will change for the better. 6) Businesses --this is an area that the Division of Community and Family Health has embarked on to a certain degree, but needs further development. 7) Ability to influence policy-making process --The Department has the ability to influence policymakers to the degree that is within the boundaries of state government roles and the Governor's agenda. The Executive Director of the Department of Health, David Sundwall, has vast experience in government

nationally which will greatly benefit public health and Title V in the state as he works to address many of the challenges we face.

State's capacity to provide:
Preventive and primary care services for pregnant women, mothers, and infants

Reproductive health services, in some degree, are offered by each of the twelve local health departments (LHDs) with 11 local health departments providing Presumptive Eligibility (PE) screening. Two urban LHDs (Salt Lake Valley and Weber/Morgan Health Departments) are sites for direct prenatal services provided by the University of Utah Health Sciences Center and the Midtown Community Health Center Family Practice, respectively.

During the past few years, the PE system has become a barrier to prenatal care in Salt Lake due to restrictions on PE determinations for private provider clients by the Qualified Provider sites. The Division initiated "Baby Your Baby by Phone" for women to obtain PE on the phone, which has been effective in getting eligible women on PE to access prenatal care. The Division has been working with a contractor to develop an on-line application system, UtahClicks, for PE, Medicaid, Early Intervention, and CSHCN. UtahClicks was rolled out in 2006 and has been effective in facilitating access to these programs for the public. Future programs to be added include WIC and Head Start.

Eleven LHDs provide presumptive eligibility determination, and 10 obtain a prenatal history, including obstetrical, nutritional, socioeconomic, and a brief psychosocial review. Risk factors are identified and a plan of action developed. The mother is assisted in finding a provider and referrals to other resources are made based on her need.

Availability of enhanced prenatal services varies among the health districts and even among an individual health district's sites. Federal MCH funding has been allocated to two agencies, Salt Lake Valley Health Department and the Community Health Centers, Inc., to support prenatal services to uninsured women in Salt Lake City. Depending on a client's payer, all or a portion of the enhanced prenatal services (perinatal care coordination and pre/postnatal home visiting, nutritional counseling, psychosocial counseling and group pre/postnatal education) is available directly or by referral to other agencies.

Complete family planning services are only available in eight local health districts. Two other districts provide partial services by obtaining medical histories, providing education on contraceptive options and by subsidizing oral contraceptives and physical examinations by private providers. Another district provides only Depo-Provera on-site but subsidizes oral contraceptives for private providers' low-income women. One rural health district has no publicly funded family planning services available in its jurisdiction. /2008/ As access to low cost contraceptives impacts more LHDs, fewer will be able to provide the services although they recognize there is great need in their communities for family planning. The Reproductive Health Program sponsored a training on two methods of natural family planning which was very well received. One local community-based organization will be teaching these methods to Hispanic women in their community through a small amount of funding from Title V. //2008//

The University of Utah Health Sciences Center has a comprehensive program for pregnant teens and their young children in Salt Lake City, partially funded by MCH Block Grant monies, which includes PE, prenatal care, WIC, and intensive follow-up for the mothers to prevent rapid repeat pregnancies, and well child care for infants.

Low cost reproductive health services on a sliding fee scale are available in Wasatch Front and rural community health centers. Family planning services are available on a sliding fee scale through Planned Parenthood Association of Utah (PPAU), the state Title X agency. However, in the rural areas of the state, family planning services are not readily available through local health departments or PPAU clinics. MCH has developed a strong relationship with PPAU with much

collaboration between the two agencies on a number of common issues. PPAU is currently collaborating with two LHDs to provide emergency contraception for qualifying women.

Comprehensive health care for homeless individuals is available through a Salt Lake clinic, including PE and family planning through a contract with PPAU. Centro de Buena Salud, a migrant health center in northern Utah, provides PE screening and prenatal care to eligible women. Prenatal care and family planning services are available to Native American women in the Salt Lake City area through the Indian Walk-In Center via contracts with Community Health Centers, Inc.; for the Southeastern area of Utah via the Utah Navajo Health Systems, Inc., and through the Indian Health Service facility on the Fort Duchesne Ute Reservation in northeast Utah. Women enrolled in the Shoshone Band in Box Elder County may receive reproductive health services via contract with local providers.

Three programs in the Bureau of Children with Special Health Care Needs address newborns: the Newborn Screening Program the Neonatal Follow-up Program, and the Hearing, Speech and Vision Services (HSVS) Program. Both the Newborn Screening Program and the Hearing Speech and Vision Services are state mandated programs. The Newborn Screening Program oversees the state newborn blood screening and ensures follow-up for those infants whose screens were positive. Newborn Screening Program has a multi-disciplinary Newborn Screening Advisory Committee and receives guidance from the Department's Genetic Advisory Committee. The HSVS Program oversees and supports the newborn hearing screening program by maintaining a comprehensive (child) database, aggressive tracking of newborns, a multidisciplinary advisory committee that reviews and provides guidance, and a system that provides an annual evaluation of the state's newborn hearing screening and follow-up performance. The Neonatal Followup Program follows very low birth weight newborns through their first two and a half years of life.

The Tobacco Control and Prevention Program has worked with the Reproductive Health Program and Medicaid to promote tobacco cessation among pregnant women throughout the state. Utah's Medicaid prenatal benefits include counseling and/or appropriate pharmaceuticals to assist pregnant women in smoking cessation efforts.

Preventive and primary care services for children

/2009/ Primary care services for children are provided in a variety of settings, private practice, local health departments, community health centers, and other sites, such as free clinics. Children eligible for Medicaid along the Wasatch Front are enrolled in one of two HMOs that the Department contracts with for services to the Medicaid population. Local health departments do not provide primary care services for children, but rather provide services such as immunizations for the children in their districts.//2009

The HSVS Program oversees the hospital newborn screening program and statewide consultation, education, and clinical services in the areas of communicative disorders (speech-language development and hearing) and preschool vision screening.

Secondary disabilities prevention is a critical endeavor and birth defect surveillance programs have a unique opportunity to identify infants and provide information for families regarding available services. When a child is diagnosed with a structural birth defect, Utah Birth Defect Network (UBDN) staff members are available to provide information about a particular defect, referral for health care, social or financial information. At the delivery hospital each mother is given a brochure about newborn metabolic screening, which includes information about the UBDN with the local and toll-free telephone number. UBDN has a web site that provides all necessary contact information (email, telephone, fax) for UBDN staff, as well as local and national links to other informative web sites. Families or health care providers may contact the UBDN Director or other staff members at any time, an approach that represents a passive outreach activity. In the future, the UBDN would like to take a more active approach,

making certain that all families that qualify for a particular service obtain the necessary assistance to help their child. Linking families with other families that have children with similar birth defects is also a need repeated in focus groups and women who contact the UBDN. The UBDN is projected to be rolled into the CHARM (Child Health Assessment Record Management) project during 2005. This integration of data sets will facilitate children getting into services provided by the UDOH and other agencies as well as notifying community health care providers of needs associated with the child's particular birth defect (i.e., infants with Down Syndrome should have a echo cardiogram to rule out cardiovascular disease).

Although all local health departments and community health centers are Vaccine for Children (VFC) providers, there are areas in the state with a shortage of VFC providers. The Immunization Program has worked diligently to increase the number of VFC provider sites by changing Medicaid provider enrollment to include automatic VFC provider enrollment unless a provider opts out of this program. The Program launched a statewide effort to increase the number of private providers enrolling in the VFC Program. This concerted effort to increase private provider enrollment in VFC resulted in an increase to 291 VFC providers in 2004.

The dental services indicator continues to be concerning since children on Medicaid have access to dental care, however, we do know that Medicaid reimbursement rates for dental care are a major barrier to dentists' willingness to provide care to children enrolled in Medicaid. The State has been served with notice of a lawsuit regarding low reimbursement rates for dental care. The Oral Health Program works closely with Medicaid to convey issues that the dental community is facing with the Medicaid program.

School nurses are employed either directly by a school district or by a local health department, which contracts with a school district to provide school nursing services. They provide a variety of services, including the development of health care plans for children with special health care needs to assist school staff in working with these children. In accordance with the Utah Nurse Practice Act and accompanying rules, school nurses may delegate certain tasks to school staff to ensure children receive the proper care they need during school hours. School nurses provide the training and evaluation for these delegated tasks, while maintaining ultimate responsibility for the outcome. School nurses also provide health teaching, staff wellness, and consultation in developing school health policies. They also serve as a liaison between school personnel, family, community, and health care providers. /2009/ Unfortunately due to budget cuts and restrictions, we are not able to fill the school health consultant position when it was vacated late 2007. Unless we are able to find additional funding, the position will not be filled. This vacancy leaves a large hole in the state's ability to support school health and school nurses. //2009//

The Violence and Injury Prevention Program interventions have focused on bicycle and pedestrian safety. Bicycle helmets are an effective safety device to reduce injury and death. It is estimated that if every Utah bicyclist used a helmet, health care cost savings would total $19 million a year. Interventions for children have also targeted other aspects of bicycle and pedestrian safety.

Services for children and youth with special health care needs

Primary care services for youth and young adults with special health care needs are not readily available throughout Utah. Advances in health care have allowed children with complex conditions to live longer and have more productive lives, however, adult primary care providers are often not familiar with the conditions and support needed for rare or complicated conditions and the support needed. Many of these children, youths, and adults with special health care needs are Medicaid recipients and low provider reimbursement rates add to the barriers of finding an adult primary care provider. Additionally, routine preventive dental care for children, youth and

adults with special health care needs is especially difficult to access. Some of the barriers include: many dentists are reluctant and/or not trained to treat children and youth with disabilities in the traditional office setting; many children and youth with disabilities are Medicaid recipients and many dentists will not take Medicaid patients due to poor reimbursement. ***/2009/ The Bureau will be applying for the HRSA autism grant funding that will help to support Utah's efforts to address autism. There is a great deal of interest in autism, especially since the rates in Utah exceed national estimates. The 2008 Legislature appropriated one-time funding to help support the state's autism registry. //2009//***

/2009/ The Bureau of CSHCN is providing state leadership to bring together representatives from the many agencies and advocates who influence the statewide system of services for children with autism spectrum disorder (ASD) and their families. The Bureau hosts the Utah Autism Initiative Committee, a multi-agency workgroup, and is an active participant on the Autism Council of Utah. The state-funded Utah Registry for Autism and Developmental Disabilities (URADD) collects and manages prevalence data on Utah children with ASD and other developmental disabilities through a contract with the University of Utah Health Sciences Center. Additionally the Bureau provides direct clinical and intervention services through the Baby Watch Early Intervention Program and multi-disciplinary diagnostic evaluation and care coordination in CSHCN clinics in Salt Lake City and 9 satellite locations. //2009//

/2009/ Beginning August 2008, the State of Utah Offices will convert to a four day work week of Monday through Thursday 7 a.m. to 6 p.m. Governor Jon Huntsman in his Work 4 Utah mandate has changed work hours and days for all State agencies in order to save energy costs and to reduce gasoline consumption for staff driving to work. The Department will track the impact that the change in business hours may have on its customers as well as its staff. The extended work day will afford easier access to services for those who work usual work hours of 8 a.m. to 5 p.m. //2009//
An attachment is included in this section.

C. Organizational Structure

In January 2005, Jon M. Huntsman, Jr. became the 16th Governor of Utah. Governor Huntsman appointed David N. Sundwall as the Department of Health's Executive Director. Dr. Sundwall comes to the Department with extensive experience in the federal and national arena. The Department of Health is a cabinet-level position in state government, thus Dr. Sundwall reports directly to Governor Huntsman.

Utah's Title V programs are administered by the Division of Community and Family Health Services of the Utah Department of Health, under the direction of George W. Delavan, M.D., a pediatrician with many years experience in public health and children with special health care needs. Dr. Delavan reports to the Deputy Director of the Department, Richard Melton, Dr.P.H. Dr. Delavan oversees the Title V programs and other programs that address the health of Utah's population. The Division is also the lead agency for Individuals with Disabilities Education Act (IDEA), which is the state Part C program, and the State's Immunization and WIC Programs. The Division website is:
http://www.health.utah.gov/cfhs

The Division is organized into three Bureaus, comprising twenty-five programs. Each program reports to one of four Bureau Directors or Medical Directors. The senior level management staff in charge of this entire Division brings a wealth of experience and depth of training to their respective program areas. They have the opportunity to lead an expert staff of approximately 300 individuals in carrying out their mission to improve the health of Utah's residents.

Organizational charts have been attached to display the organizational structure of the Department of Health and its programs. Of note, the State Medicaid agency, the Division of

Health Care Financing, is housed in the Department of Health, which facilitates the strong collaboration between Medicaid and Title V.

The Title V programs are housed in two of three Bureaus, the MCH and the CSHCN Bureaus. The third Bureau, Health Promotion, includes other programs that may address the needs of mothers and children, although not generally funded with Title V.

The Bureau of Children with Special Health Care Needs includes eight programs and the state Part C program, Baby Watch/Early Intervention. The Bureau is now headed by Holly Williams as Bureau Director and Harper Randall, MD, Medical Director, a community pediatrician who started with the Department on July 1, 2006. Holly Williams is a Master's prepared nurse with 30 years of experience. http://health.utah.gov/cshcn/

The MCH Bureau includes six programs that specifically focus on mothers and children. The MCH Bureau is headed by Nan Streeter, a master's prepared nurse who brings more than thirty years of experience to this position. http://www.health.utah.gov/cfhs/mch/

Programs that are funded by Title V
The program descriptions outlined here provide the services of preventive and primary care to pregnant women, mothers, infants, and children as well as services for children and youth with special health care needs.

Adaptive, Behavioral and Learning Environment (ABLE) Program works with families, schools and agencies and provides multidisciplinary diagnostic evaluations and school-based care coordination for services. The program also oversees Specialty Services contracts with the University of Utah and private providers for provision of specialty care to children in Neurology, Genetics, and Pediatrics.

The Birth Defects and Genetics Program houses three projects: 1) The Pregnancy RiskLine which provides accurate and current information and counseling about possible effects of maternal exposure to medications, drugs, chemicals, infections, and other diseases on a fetus and breastfed infant. This free information to improve the pregnancy outcome is provided by telephone through a toll-free line and in written follow-up to callers. 2) The Utah Birth Defect Network identifies infants born with major birth defects to determine prevalence, assess demographic distribution and to provide families with education and referral to appropriate services. 3) The Utah Genetics Project oversees the integration of genetics and genomics into public health practice. Websites include: http://www.health.utah.gov/cshcn/pregnancyriskline/ and http://health.utah.gov/birthdefect/

The Child Adolescent and School Health Program assures services to Utah's early childhood, school and adolescent populations by providing consultation to local health departments, schools, and others. The program oversees the Head Start-State Collaboration Project grant; the Prenatal-5 Nurse Home Visiting Program, the Sudden Infant Death Syndrome Program, the State Early Childhood Comprehensive Systems grant, the Abstinence Only Education grant, school and adolescent health. Website is http://www.health.utah.gov/cash/
/2009/ The program also oversees the State Partnership for Children and Adolescents grant which focuses on mental health for school age children. //2009//

Data Resources Program provides analytic resources and statistical expertise for assessing the health status of the population and planning and evaluating maternal and child health services in Utah. The MCH Epidemiologist heads this program. Analytic support is also provided to CYSHCN programs.

The Developmental Consultative Services Program is the result of a merging of two programs: the Child Development Clinic and the School Age and Specialty Services Program. This program improves care delivery to school-aged children who are at risk for or identified with complex

behavioral or learning disabilities or chronic physically disabling conditions provides multidisciplinary diagnostic evaluations and care coordination services for children up to five years of age with special health care needs. The program offers diagnostic consultation and case management services for children with multiple disabilities up to age 18 years.

Hearing, Speech, and Vision Services (HSVS) Program provides statewide screening, evaluation, and referral of infants and children with hearing, speech, and/or vision problems. Facilities are located in Salt Lake City, Ogden, Price, and Cedar City. HSVS is responsible for management of the Newborn Hearing Screening database that includes the screening and follow-up results of the state's newborns as well as the coordination (including training) of the EHDI Program. http://health.utah.gov/cshcn/hsvs/

The Neonatal Follow-up Program offers multidisciplinary services to very low birth weight and prematurely born babies statewide. The program provides periodic screening of sensory, neurodevelopmental and general health. A summary report is shared with child's primary physician, early intervention service and respective newborn intensive care unit. All summary reports are entered into a database. Trends and outcome are monitored. http://health.utah.gov/nfp/

Oral Health Program promotes prevention to reduce dental decay and other oral diseases and increase access to oral health care for pregnant women, mothers, infants, and children including those with special health care needs. The program provides technical assistance to local health departments and others in the community. The State Dental Director is housed in the program. http://health.utah.gov/oralhealth/

The Reproductive Health Program (RHP) comprises five components: prenatal to improve access to care through Presumptive Eligibility and enhanced prenatal Medicaid services; family planning to assure access to services in underserved areas; Perinatal Mortality Review to review fetal and infant deaths, and deaths of women who have recently delivered to develop strategies to prevent future deaths. http://health.utah.gov/rhp/
/2009/ Though not funded with Title V dollars, RHP oversees Utah's PRAMS project as well as a case management program for pregnant women enrolled in the health insurance company that provides coverage for government employees in the state. //2009//

/2009/ The Utah Registry of Autism and Developmental Disabilities collects prevalence data to determine prevalence rates of Autism Spectrum Disorders and mental retardation in Utah. http://health.utah.gov/cshcn/cdc //2009//

Violence and Injury Prevention Program (VIPP) works to reduce injury in the state of Utah, with a specific focus on youth injury prevention. The program has several components: school injury prevention, youth suicide prevention, pedestrian and bicycle safety, motor vehicle occupant protection, Utah Safe Kids Coalition, and, child fatality and domestic violence fatality reviews. In addition, the program works to prevent falls, rape and sexual assault. http://www.health.utah.gov/vipp/

Other Programs that are administered by the Title V agency with non-Title V funding:

Baby Watch/Early Intervention Program (BWEIP) provides early and developmental interventions statewide for young children with developmental delays and/or disabilities from birth to age three. Children with a delay in one or more of the following areas qualify for services: cognitive, motor, language/speech, psychosocial development, self-help, hearing, vision, or physical development/health. Services include multi-disciplinary evaluation and assessment; service coordination; specialty and therapy services such as nursing, physical, occupational and speech therapy, special instruction, family support and related services that build on family strengths and child potential. Services are available statewide through local agencies. Services are available to families on a sliding fee. http://www.utahbabywatch.org/

Baby Your Baby Program educates families about the importance of early and regular prenatal and well-child care and where families may obtain services. The program conducts television and radio public service announcements, the Baby Your Baby Hotline and provides free educational materials such as the Baby Your Baby Health Keepsake, newsletters, and other incentives. http://www.babyyourbaby.org/

Center for Multicultural Health works with Department programs and the minority and ethnic community on health issues related to specific populations in the state.

Community-Based Services Program (CBS) provides care coordination to a target population of 120 technology dependent children statewide through Medicaid's Travis C. Waiver. This program also includes the Medical Home staff and the CSHCN Parent Advocate Coordinator.

Fostering Healthy Children Program (FHCP) assists the Division of Children and Family Services (DCFS), the state child welfare agency, in meeting the health care needs of children in foster care by co-locating nurses with DCFS case workers and providing administrative medical case management. for almost 4000 children through the "SAFE" information, the Statewide Automated Child Welfare System. http://www.health.utah.gov/cshcn/fhcp/

Heart Disease and Stroke Prevention Program targets all ages, but specifically has developed a school-based program called Gold Medal Schools which promotes healthy eating and physical activity.

Immunization Program is funded through CDC grant funding. The Program assures that Utah's children are adequately immunized and assures that the components of a statewide immunization program as required by CDC are addressed. http://www.immunize-utah.org/

Newborn Screening Program provides a statewide system for early identification and referral of newborns with any of four disorders (phenylketonuria, galactosemia, congenital hypothroidism, and hemoglobinopathies) that can produce mental retardation or death if not treated early. Hospitals are charged a fee for the testing kit which funds the lab testing and nursing follow up of identified children. By January 2006, the program will incorporate screening for Congenital Adrenal Hyperplasia, Biotinidase and disorders identified through tandem mass screening to the mandated newborn blood screening panel. /2008/. The program now screens for 36 disorders. //2008// http://www.health.utah.gov/newbornscreening/ ***/2009/ Screening for Cystic Fibrosis will begin in 2009. //2009//***

Tobacco Prevention and Control Program provides technical expertise and coordination at the state and community level to prevent and reduce tobacco use in youth and adults including pregnant women through educational and cessation programs and policy development. Efforts to enhance tobacco-free policies include increasing the number of tobacco-free outdoor venues frequented by youth (parks, arenas, rodeos, etc.) and supporting a change in Utah's Indoor Clean Air Act to protect employees of bars and clubs from workplace exposure to secondhand smoke. http://www.tobaccofreeutah.org/

WIC (Women, Infants and Children) is the USDA-funded supplemental food and nutrition program. WIC provides evaluation of nutritional risk, nutrition education, and food vouchers to pregnant and breastfeeding women, and children up to age 5 who meet program eligibility criteria. http://health.utah.gov/wic/

Other programs that include strategies that impact mothers and children include Asthma, Arthritis, Cancer, Center for Multicultural Health, Diabetes Prevention and Control and Genomics programs.

An attachment is included in this section.

D. Other MCH Capacity

Division program planning and evaluation occur at the program level with support from Division data resources as well as Department-level data analytical resources. The Division has dedicated staff that provides data analysis to aid the Division Director, Program Managers and Bureau Directors in planning and evaluation processes. In December 2002, after several years of searching for an appropriate candidate, the Division reorganized the Division-level Data Resources Program to a Bureau of Maternal and Child Health program to better support the data needs of the Bureau. This change resulted in filling the position of MCH Epidemiologist with the Manager of the Data Resources Program who has proven to be very skilled and adept for the position.

Data capacity is strong in the Utah Department of Health (UDOH) including in the Division of Community and Family Health Services. The Department's Center for Health Data provides a great deal of support for Title V data needs by offering direct access to vital records, hospital discharge data, and a variety of health status and health care data. One of the major strengths in the data infrastructure of the UDOH is the on-line Indicator-Based Information Query System (IBIS). This system acts as the primary point of data access and houses birth, death, hospital discharge, BRFSS, Health Status Survey, PRAMS, Cancer Registry, injury and other public health data. The system includes a number of data sources related to mothers and children. Division staff is very familiar with this system and utilizes it on a daily basis, allowing more timely access to data.

Data Resources and MCH PRAMS staff collaborates with various UDOH programs and has established a network (MCH Epi Network) to share data issues related to the MCH populations. ***/2009/ The MCH Epi Network has been well attended by Title V staff as well as staff from programs not funded by Title V. Other regular attendees include staff from the Center for Health Data, Vital Records and others. //2009//*** In addition a data group specific to each of the five programs in the MCH Bureau has been meeting to discuss common data needs and interests in further work. MCH staff continues to partner with Medicaid in order to link birth and Medicaid eligibility data to assess birth outcomes among Medicaid women. Due to the recent development of Medicaid Data Warehouse, accessing eligibility and claims data has been more easily attainable.

Since the data capacity of the Department is strong, the Division has successfully submitted abstracts to the Annual MCH Epidemiology Meetings, which have resulted in several presentations and poster sessions at the meetings for a number of successive years. Staff in the other Bureaus of the Division has also submitted abstracts and presented at other national meetings.

Number and location (central and out-stationed) of staff that work on Title V programs

The Division staff members are housed in two buildings in Salt Lake City, the main Department of Health Building, the Martha Hughes Cannon Building, and the clinical services building, the Center for Children with Special Health Care Needs. The Center for Children with Special Health Care Needs is conveniently located within walking distance of Primary Children's Medical Center (PCMC) and the University of Utah Health Sciences Center (UUHSC) and within one mile of Utah's Shriners Hospital for Children.

The majority of CSHCN staff is based in the Salt Lake City office. CSHCN offers a number of clinical services at the Salt Lake City office as well as others in Provo, south of Salt Lake, and Ogden, north of Salt Lake. Some Salt Lake City based staff provide services in outlying areas of the state through traveling clinics, while other state staff are stationed outside of Salt Lake to provide services in local communities outside the Salt Lake area. For example, there are twenty-seven nurses working in the Fostering Healthy Children Program throughout various parts of the

state. The Hearing Speech and Vision Program, in addition to the Salt Lake staff, has 4 employees out stationed in the southern part of the state (Cedar City) the eastern part of the state (Price) and in Ogden. These staff members include three audiologists, a speech pathologist and two support staff. The CSHCN pediatric clinics have 3 employees who are out stationed in Ogden. ***/2009/ and 2 employees stationed in St. George, a growing community in southern Utah //2009//*** in addition to contract staff in 7 other rural Local Health Department satellite sites that support the itinerant multidisciplinary clinics. These satellite offices are staffed by a total of 18 RNs and health program specialists. The Utah Collaborative Medical Home project has worked with pediatric and family practice providers to enhance their capacity to provide medical homes for children with special needs. Trained Medical Home teams (physician, nurse and parent advocate) are now established in Montezuma Creek, Orem, Salt Lake (4), Ogden (2) and Logan. Ongoing technical assistance and support is provided to these teams through CSHCN and University of Utah staff, as well as through the MedHome Portal website.

Number and role of parents of special needs children and youth on staff

The CSHCN Bureau has hired the Director for the Utah Chapter of Family Voices (UFV), who is the parent of four special health care needs children. She has over 19 years of experience in parent self-advocacy training through the Utah Parent Information and Training Center (UPC) and she has been very active in the Utah Medical Care Advisory Council for Medicaid, the Utah Legislative Coalition for People with Disabilities and the ULEND project. She has been integrally involved with the establishment of Utah Collaborative Medical Home Project and has provided support to the parent advocates in the individual Medical Home practices across the state. There are nine trained Family Advocates in the Utah Collaborative Medical Home Project. The Bureau also contracts with LINCS to provide parent support and advocacy to parents of patients who are served through the rural traveling clinics. Through LINCS, there are trained family advocates in each of the eight rural CSHCN Satellite areas.

CSHCN is also collaborating with Utah Family Voices (UFV) and the Utah Parent Information and Training Center (UPC) in the implementation of a Center for Medicaid and Medicare Services (CMS) grant, awarded to UPC and UFV in October 2004. This three-year project is housed at the UPC and is designed to establish a Family-to-Family Center. CSHCN has dedicated $50,000 of MCH funding to enhance family-to-family activities and support development of a family database. Through this grant two Family Health Partners have been hired and trained to assist in family-to-family health information and education. Also this funding will be used to reimburse families for their consultation and involvement in development of materials for various family-to-family projects, such as the CMS Family-to-Family project, the Utah Collaborative Medical Home project, the ULEND project and medical residency training. This funding will also set up a toll free information and referral line, staffed by trained parents.

Through the Family to Family grant, a statewide Family Advisory Committee will be established which will include families of CYSHCN, a young adult with special needs, key CSHCN Bureau staff, private providers and a representative from Medicaid. The Utah Collaborative Medical Home Project will collaborate in the establishment of this committee. The stakeholders in this committee will insure that the Family-to-Family Center project is effective in addressing the needs of Utah families of children and youth with special health care needs. Utah Family Voices received a Health Insurance and Financing Technical Assistance Initiative through the Maternal Child Health Bureau. Through this technical assistance initiative, UFV will conduct focus groups of parents to ascertain the issues facing parents of CSHCN related to health care insurance and funding. The results will be used to develop a parent focused tool kit for the MedHome Portal website. The findings will also be published for key stakeholders to use in outreach efforts and policy development. ***/2009/ The Family to Family grant was awarded to Utah Family Voices in 2008 //2009//***

The Utah Family Voices Director is involved with the Family Advisory Committee through Primary Children's Medical Center, which is Utah's tertiary care pediatric facility. Work through will help to

develop best practice policies for providing family centered care through this facility. Additionally, issues of discharge planning and linking hospital care to community services for children and youth with special health care needs are being addressed. This advisory committee has also been established as a forum in which families of children and youth with special health care needs can have issues and problems related to hospital care resolved.

The toll-free Baby Your Baby Hotline provides information and referrals on providers and/or financial assistance for prenatal care, family planning, well childcare, nutrition services, or other related services. The hotline staff collaborates well with community resources to ensure that information is current. The hotline is viewed as a valuable resource for both callers and community resources.

E. State Agency Coordination

The Utah Title V agency coordinates efforts with numerous other Department of Health programs, other state agencies, private not-for-profit organizations and community-based agencies.

Human Services Agencies
The Division of Community and Family Health Services coordinates efforts for the MCH/CSHCN populations with many other agencies in the state. The Division of Community and Family Health Services works closely with the Department of Human Services, which serves the maternal and child population statewide related to child welfare, mental health and substance abuse. /2008/ The Division has developed a collaborative working relationship with Division of Children and Family Services and Child Protective Services in a number of efforts, including the Governor's Child and Family Cabinet, Child Abuse Network, and efforts to expand home visiting for high-risk populations. The Cabinet is quickly moving forward with the priorities set by the Governor which include early childhood, child abuse, domestic violence and methamphetamine. Title V staff are involved in these efforts especially related to the early childhood area. //2008//

Department of Health staff has sought to strengthen the relationship with the Department of Human Services Division of Substance Abuse and Mental Health (DSAMH). Recent administrative changes in the Department of Human Services and in the Division of Substance Abuse and Mental Health (DSAMH) have led to a difference in approaches, including welcoming collaboration and input with the Department of Health. The DSAMH received a five-year grant, UT CAN - Utah's Transformation of Children and Adolescent Network, to improve the mental health service system infrastructure for children and youth throughout Utah. Title V staff participate on the Steering Committee and subcommittees. We have worked with the DSAMH on our efforts to promote mental health for children and on postpartum depression. DSAMH recently hosted a all day meeting on Mental Health and Physical Health which we have been promoting for a number of years.

The Bureau of CSHCN is collaborating with this effort especially through its Medical Home initiatives, including the MedHome Portal website. CSHCN Bureau staff participates on the Health Care Consortium Council for the Division of Child and Family Services (DCFS), Utah's child welfare agency, which advises the DCFS Board on health issues for children in their system. The Fostering Healthy Children Program (FHCP) co-locates CSHCN nurses with DCFS caseworkers to assist them in coordinating health care. Since all foster children in Utah are covered through Medicaid, FHCP collaborates closely with Medicaid to ensure that services are accessible for these children. Two Division representatives sit on the DCFS Child Abuse and Neglect Council, and an inter-agency group, Utah Prevention, to address substance use and other issues among youth. Multiple Division representatives are on an inter-agency group to address youth transition

issues.

The Baby Watch/Early Intervention (BWEI) Program works with DCFS to develop policy and procedures for the Child Abuse Prevention Treatment Act (CAPTA) requirements for referral of children with substantiated abuse and neglect to BWEI. New DCFS procedures for child protective personnel will require developmental screening of children birth to three at the initial home visit. Children who show potential problems will be referred to BWEI. Local BWEI agencies will partner with local DCFS personnel to train on the developmental screening tool and design referral procedures for children suspected of a developmental delay. BWEI and DCFS received a $10,000 grant from the National Association of State Directors of Special Education to support this work.

The Inter agency Coordinating Council (ICC) provides advice to BWEI. The ICC membership, representing statewide early childhood services community, is comprised of 25 members. The state is able to bring together clinical staff, political appointees, parents of special needs children, and administrative representatives of various agencies or providers such as mental health, human services, education, Department of Insurance, Head Start, Workforce Services, Division of Services for People with Disabilities, physicians and representatives from contract Early Intervention providers. The ICC provides a broad vision of the service system based upon the participation and contributions of relevant providers and consumers.

Title V staff work collaboratively with other state agencies, such as the Office of Education, Juvenile Justice, School for the Deaf and Blind, the Office of the Courts, Utah Highway Safety Office, to name a few to improve the health of mothers, children and children and youth with special needs. CSHCN Bureau and the Office of Students at Risk (SARS), the state special education program, enjoy a strong working relationship and have collaborated on a number of projects, such as Medical Home and the development of several Learning Modules on the MedHome Portal. A SARS staff member sits on the MCH Advisory Committee and the Medical Home Advisory Committee. CSHCN Bureau and SARS have worked together on the Utah Registry for Autism and Developmental Delays (URADD) grant.

Medicaid
Title V enjoys a strong relationship with Medicaid, helped by the fact that Medicaid is housed in the Department, thus the two are "sister" Divisions. Utah's CHIP Program, a stand-alone program, is administered by Medicaid. The Division has a MOA with Medicaid that promotes collaboration between the two agencies. The Division works closely with Medicaid staff on EPSDT and other Medicaid administered programs. Medicaid provides match for a number of programs that serve the Medicaid populations, such as Baby Your Baby outreach, PRAMS, etc. Medicaid developed targeted case management (TCM) for children up to age four in collaboration with Title V staff.

Title V staff participate in quality assurance review of the managed care organizations or PPO that provide services for the Medicaid population. Reproductive health, child health and CSHCN staff participates in reviews with Medicaid to ensure that MCH/CSHCN services are appropriate and comprehensive. These programs also work closely with Medicaid to certify smoking cessation interventions for pregnant Medicaid participants; provide case management to a subset of high-risk pregnant Medicaid women; and to ensure information for, outreach to and access for Medicaid eligible children and youth with special health care needs and their families. Two Medicaid eligibility workers at the CSHCN clinics work with the Travis C. Waiver Program, clinics and other Medicaid staff at two adjacent tertiary care facilities. ***/2009/ The CSHCN Medical Director is a voting member of the Medicaid Prior Authorization Committee and CSHCN staff serves as consultants. In addition, the State Dental Director is a voting member of this committee. MCH/CSHCN staff are no longer involved in the quality monitoring of services to mothers and children in HMO or PPO contractors. The Division had been involved for a number of years in this effort and state Medicaid staff have been able to take this function over. //2009//***

Title V staff collaborated with Medicaid on a grant-funded project, ABCD II, which promotes social emotional screening of young children and assessment of postpartum depression. The project's work is sustained through the MCH Bureau through promotion of social emotional screening of young children. MCH Bureau staff has worked with Medicaid on a family planning waiver that we hope to get legislative approval on within the next year. ***/2009/ We continue to work on the family planning waiver and currently are in the process of documenting costs savings that would be realized if the waiver were implemented in Utah. //2009//***

The Oral Health Program has well-established relationships with Medicaid and CHIP to improve accessibility to Medicaid/CHIP dental services. Program staff collaborated in defining a basic scope of CHIP dental benefits; ensuring that CHIP children can be seen by "any willing provider"; and, expanding CHEC (EPSDT) outreach programs for case management for children needing dental services. CSHCN Bureau staff participates in Medicaid's Utilization Review and CHEC Expanded Services Committee to determine coverage of non-covered services for Medicaid recipients. The CSHCN Bureau Director has voting status on the committee and the Bureau's Physical Therapy supervisor is a consultant to the committee.

SSI, DDS and Vocation Rehabilitation
The SSI Specialist position in CSHCN, established over ten years ago, continues to work with the Office of Disability Determination Services (DDS) that evaluates disability claims for SSI eligibility by reviewing DDS claims and providing outreach and referral for potentially Medicaid eligible children. The specialist provides information, referral and enabling services to families having difficulty accessing or utilizing services, such as Utah Legal Services, Disability Law Center or DDS. CSHCN Bureau staff participates on the DDS Advisory Committee that has fostered cross training of CSHCN Bureau and DDS staff. CSHCN has a staff member on the Traumatic Brain Injury Advisory Committee, housed in the Vocational Rehabilitation office. A member of Voc Rehab sits on the CSHCN Medical Home Advisory Council. The MedHome Portal Website has worked with Vocational Rehabilitation office advisors to develop the transition to adulthood module. CSHCN staff members are active in the Utah Center for Assistive Technology Center under Vocational Rehabilitation on advisory boards and in coordinating direct care for individuals with disabilities.

Family Leadership and Support Programs
CSHCN has hired the Utah Family Voices Director to provide consultation and support to CSHCN programs and families, and to infuse and enhance family-centered values into CSHCN Bureau programs and initiatives. The Family Voices Director works closely with the Utah Parent and Information Center in teaching and mentoring other families of children and youth with special health care needs. CSHCN also contracts with the Liaison for Individuals Needing Coordinated Services (LINCS) to provide direct services. CSHCN includes families in the inter agency coordinating council for Part C.

Local public health agencies
The relationship between the local health departments (LHDs) and the MCH/CSHCN programs has been strong, although in previous Department administrations it has been strained due to the shift of services to managed care organizations and tensions over limited funding. Dr. Sundwall, the Department's Executive Director, has made a commitment to working with local health departments. He appointed a Department liaison, a position that had been previously abolished. The Department plans to work with the local health departments to develop a state public health plan. ***/2009/ The Department leadership and the leadership of the local health departments have been working on the state public health services plan and are at a point in which it is clear that there is not enough funding for public health services either at the state or local level. Two Legislative Committees, the Political Subdivisions Committee and the Health and Human Services Appropriations Committee, are looking into the Department's allocation of funding to local health departments versus the proportion that the Department uses to provide its public health functions. The Department has already***

reallocated more than $1 million in bioterrorism funding to local health departments to build their capacity. Local health departments have discussed a number of options, but none seem to be very viable at this point. //2009//

Each local health department determines the MCH services it will provide based on resources, community priorities, and need. Each district receives MCH block grant funds for services, although each varies on which services it provides. MCH program staff works closely with local health department (LHD) staff. To support the current contract requirements for MCH for a community needs assessment, MCH staff provides technical assistance and consultation as needed. The Bureau of Children with Special Health Care Needs contracts with several LHDs to coordinate clinical services for the itinerant clinics in rural areas. State staff meets with local health officers and nursing directors during their quarterly meetings as needed or requested. Representatives of the local health officer association and the local nursing director association participate in various Division advisory committees or task forces to ensure their input and support.

/2009/ Examples of services provided by local health departments include:

The Oral Health Program has been working with local health departments to improve oral health awareness by awarding small grants funded by a HRSA grant to support local oral health activities. /2009/ This grant funding has ended, however, program staff continue to work with local health departments to support existing coalitions and the development of new local coalitions in districts without one. //2009//

Federally qualified health centers and state primary care association
While the relationship with community health centers is positive and collegial, it needs to be nurtured more since they are critical primary care providers for a large population of uninsured individuals. Division staff has a stronger more collaborative relationship with the State Primary Care Association, State Primary Care Organization and the community health centers by invitations to sit on Division advisory committees, etc. We contract with the Salt Lake community health centers for prenatal care for uninsured women. The Immunization Program contracts with the State Primary Care Association (AUCH) for immunization outreach in community centers through the state. The contract with AUCH is to increase immunization rates among populations served by community health centers. The contract relationship has grown over the past five years and is a strong collaborative effort. A small contract of MCH dollars is given to the Salt Lake community health centers for prenatal care for uninsured women. The Oral Health Program works with AUCH to provide technical assistance to their dental clinics and encourage the addition of dental clinics in other community health centers.

Title V staff has for the past two years been invited to review grants submitted by community organizations and local health departments for the Department's primary care grant program. Projects funded include many working to improve oral health, family planning services, mental health and other services that are needed by MCH populations in the communities. ***/2009/ Staff continue to participate in the grant review process for the primary care grant program. This program is an important one as it funds clinics and/or services that would otherwise not be available. Grants area awarded to agencies in urban and rural/frontier areas of the state. //2009//***

CSHCN included the Navajo Reservation-based Montezuma Creek Community Health Center in the initial 2001 Utah Medical Home project. The Family Practice provider team of participated in the Medical Home training project. Although the grant has ended, this practice team continues to be an active Medical Home site having added four members to their team.

Tertiary care facilities
The Division has effective relationships with the tertiary facilities in the state, five perinatal centers and two children's centers. ***/2009/ We now have six perinatal centers in the state. //2009//*** The

University of Utah Health Sciences Center, a tertiary perinatal center works closely with MCH Bureau staff. University faculty are involved in a number of Department efforts to improve health of mothers and children.

Primary Children's Medical Center (PCMC) and Shriners Hospital for Children, the two children's hospitals in the state, work closely with the Bureau of Children and Youth with Special Health Care Needs to coordinate services for children with special needs. PCMC physicians participate in the Department's Child Fatality Review Committee to identify those deaths that possibly are preventable.

The Utah Collaborative Medical Home Project, a collaborative effort with the University of Utah Department of Pediatrics, Utah State University, Medicaid and Utah Family Voices, provided outreach and support to medical homes statewide for children with special health care needs ***/2009/ up through April 2008 when grant funding ended. Currently CSHCN provides support through monthly educational phone conferences, newsletters and yearly site visits. //2009//***. The project is guided by an advisory committee of private pediatric and family practice physicians, families, allied health professionals and other partners, such as education, vocational rehabilitation and Medicaid.

/2009/ Pediatricians from the University of Utah Department of Pediatrics are contracted to provide developmental pediatric assessments at CSHCN Salt Lake City and satellite clinics. Neurologists and Geneticists from the University of Utah are contracted to provide sub-specialty evaluations at CSHCN satellite clinics. //2009//

The PCMC strategic plan for children and youth with special health care needs includes support of Medical Homes. The CSHCN Medical Director serves on the PCMC Pediatric Education Services Continuing Medical Education Committee, which credentials physician CME credits and identifies topics for Pediatric Grand Rounds. The CSHCN Medical Director is involved in University of Utah and PCMC based health services research committee. The CSHCN Family Advocate Coordinator serves on the PCMC Family Advisory Committee.

Intermountain Healthcare, the largest health system in the state, owns three perinatal and one pediatric tertiary care centers. Department staff works with providers in these centers on a number of initiatives, including induction policies, appropriate delivery site for low birth weight infants, electronic medical records, Perinatal Task Force, etc.

Public health and health professional educational programs and universities
Two schools of public health offer a Master of Public Health degree and one offers a PhD in Public Health (University of Utah and Brigham Young University). ***/2009/ In the past year, a third MPH program has been started at Westminster College in Salt Lake City. //2009//*** MCH and CSHCN staff is involved with several colleges and Universities in providing internships for students in these programs and others, such as nursing, pharmacy, pediatric medicine, social work dental hygiene, and health education.

Title V programs have employed several health profession students for different projects, such as Medical Home, and reproductive, adolescent and oral health. Department of Health staff has participated in teaching classes in many of these programs.

University faculty participates in various Title V activities. The University of Utah Departments of Family and Preventive Medicine and Obstetrics and Gynecology invited Division staff to collaborate on a perinatal Epidemiology workgroup for projects related to mothers and children. The Department of Obstetrics and Gynecology asked the MCH Epidemiologist to support data needs for a NIH-funded fetal death project. University Department of Family and Preventive Medicine, Department of Pediatrics and Department of Obstetrics and Gynecology representatives sit on the Perinatal Task Force, the PRAMS Advisory Committee and others. Staff from these departments, as well as the College of Nursing, participate in the perinatal

mortality review committee. Members of these groups are regularly available for technical and clinical questions.

Department of Pediatric faculty serves on CSHCN advisory committees, including the Early Intervention Inter agency Coordinating Council, the Medical Home Advisory Council, the Newborn Hearing Screening Advisory Committee and the Genetics Advisory Committee.

The Utah Department of Health collaborated with the Nevada State Health Department to develop the Great Basin Public Health Leadership Institute, (GBPHLI) which graduated its first and second classes in Spring 2005 and 2006. The third class of GBPHLI scholars started in May 2006. The Department leadership capacity will be enhanced as more Department staff graduate from the Institute.

Title V staff has been actively involved with the Rocky Mountain Public Health Education Consortium which provides a number of educational offerings through on-site educational opportunities, such as the MCH Summer Institute, a MCH PH Certificate Program through the University of Arizona, and distance learning opportunities, such as on-line modular courses The Consortium is a collaboration of academic and state, local and tribal MCH leaders working to provide workforce development opportunities for public health professionals working in areas of with a dearth of educational programs.

Utah CSHCN is in its third year of the MCHB-funded Utah Leadership Education in Neurodevelopmental Disabilities (ULEND) program. CSHCN collaborates with Utah State University, Center for Persons with Disabilities and University of Utah, Department of Pediatrics, in an MCHB Leadership Grant. ULEND provides opportunities for students and professionals in health related disciplines (pediatrics, physical and occupational therapy, speech-language pathology, psychology, nutrition, social work, audiology, pediatric dentistry, genetics, nursing, business/marketing, special education, and families) to increase their knowledge and skills in providing services and supports to children with neurodevelopmental disabilities.

Other federal grant programs
The Division is the recipient of a number of federal grants from CDC, USDA, HRSA, etc., including WIC, Immunizations, PRAMS, Preventive Block Grant, disease-specific prevention grants such as arthritis, cancer, and others. ***/2009/ The Division has been recently awarded a CDC obesity prevention grant as well as a Wise Woman grant. These grants will enable the Department to better address obesity as well as health disease and stroke prevention. We have submitted applications for several other grants, such as SAMHA's Project LAUNCH, MCHB's First time motherhood grant, and the ACF grant for home visiting programs. //2009//***

WIC
The state WIC Program is located in the Bureau of Maternal and Child Health, which greatly enhances opportunities for coordination of efforts. WIC has a strong collaboration with other programs focused on the health needs of mothers and children. Other programs have enthusiastically welcomed the collaboration opportunities with WIC. WIC staff members participate on various committees related to maternal and child health, including the Perinatal Task Force, MCH Epidemiology, immunizations, nutrition, and data integration efforts.

The Immunization Program and WIC have collaborated on an incentive program for WIC-enrolled children who are adequately immunized at age two. WIC is currently engaged in a pilot of one small WIC clinic in which parents whose children are not up to date on immunizations can update the immunizations at the clinic or do so at a later date. Those who do not update their children's immunizations are issues vouchers for one month only until the children are caught up. WIC staff provides nutritional expertise for other program efforts, such as in helping the PRAMS program develop a report on obesity in pregnancy.

The challenge remains, however, to get local agencies to view WIC as a program that has opportunities to promote healthy mothers and children through collaboration and integration of services. WIC committed to funding a half-time data analyst in the Data Resources Program to support review and analysis of WIC data. Program staff has much improved access to use of WIC data for program planning.

Family Planning Programs
The Title V agency has a strong relationship with the state Title X agency, Planned Parenthood Association of Utah (PPAU). The Chief Executive Officer of PPAU has participated for a number of years on various advisory committees and task forces to address the needs of women of reproductive age in the state. The Reproductive Health Program provides technical assistance and consultation to local health departments on family planning services.

Pregnant women and infants eligible for Title XIX and assist them in applying for services
The Division has MOAs with 25 agencies to provide screening for presumptive eligibility (PE) for prenatal Medicaid at 53 sites throughout the state, including local health departments, community health centers, a farm worker health program, a homeless clinic, Indian Health Service provider, clinics, and hospitals. The Division provides telephone presumptive eligibility screening for Salt Lake County residents through Baby Your Baby by Phone.

The Baby Your Baby Hotline (BYB) refers callers needing financial assistance for prenatal care to a nearby PE site. WIC staff also refers women to PE as needed. Women are then referred to an eligibility office to apply for Medicaid.

The Division works with BYB on promotion of BYB as a resource for information on financial assistance for prenatal care and other maternal and child health related information.

Utah Clicks, a web-based on-line screening and application system rolled out early 2006, enables families to easily apply for services, such as PE, Medicaid, Head Start, CHIP and others, thus reducing time in clinics or eligibility offices.

F. Health Systems Capacity Indicators

Introduction

The Health System Capacity Indicators are measures to some degree of the capacity of Utah's system of health care for mothers and children.
a) The Program's ability to maintain or improve the HSCIs is facilitated by review of the data to determine if we are moving in the right direction or not. This information may tell us that we need to continue doing what we're doing, adapt what we are doing in a continuous quality improvement process, or discontinue the work as we are definitely not making progress or the indicator is declining because of what we are doing.
b) We are able to monitor trends in the indicators to tell us if we are making progress and if not, we have an opportunity to examine the indicator and its related factors to try to determine why progress is not being made. The information is helpful for us to plan to amend or cease what we are doing, and develop new strategies that are more effective.
c) Interpretation of the data includes a collaboration between program staff and data staff to ensure that each understands the context of the issue and the data quality. We always operate from the perspective of team work and require collaboration between data and program staff. This approach has been very successful for us and results in higher quality work.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	18.6	18.8	16.4	14.6	14.6
Numerator	441	459	409	372	372
Denominator	237384	244299	249960	255456	255456
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Numerator: hospital discharge database in IBIS; ICD-9 codes for asthma are 493.0-493.9. 2006
Denominator: population estimated for children 0-4 years old found in IBIS, population estimate 2006 based on GOPD 2008 baseline.

Notes - 2006
Numerator: hospital discharge database in IBIS; ICD-9 codes for asthma are 493.0-493.9. 2006
Denominator: population estimated for children 0-4 years old found in IBIS, population estimate 2006 based on GOPD 2008 baseline.

Notes - 2005
Numerator: hospital discharge database in IBIS; ICD-9 codes for asthma are 493.0-493.9. 2004
Denominator: population estimated for children 0-4 years old found in IBIS. 2005

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSCIs?

The Asthma Program, which is funded with CDC funds, sponsored a learning collaborative for pediatric providers to improve their management of children with asthma, such as diagnostic standards, having an action plan for the child, and so on. The Learning Collaborative was conducted by UPIQ (Utah Pediatric Partnership to Improve Healthcare Quality) and data were collected to look at provider practice change. The Learning Collaborative showed improved use of management tools for children with asthma, such as the action plan form developed by the Program.

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

The Asthma Program has just released it new five year plan for 2007 -- 2011. The plan was prepared with partners, such as the American Lung Association, the Asthma Task Force and others. The State plan is written to address several levels of Utah society including: schools, community, health systems, environmental, and others. The Plan addresses the following areas:

Asthma Management
Health Systems
Population Issues
Risk Factors
Data and Monitoring

Each of these areas has a specific plan of action to address the issues identified by the group involved in the development of the new plan.

The Asthma Program has added numerous resources for health care providers and the public to

its website. These resources include information on adult and pediatric issues related to asthma. Coming soon will be additional resources, such as a health care provider manual, guidelines for providers in managing adult asthma and pediatric asthma as well as a guide to asthma and medications. There are many resources on the Utah Asthma Program website that are from a variety of sources as well as those that the Program has developed. The website address is http://health.utah.gov/asthma/

The Program also sponsored a learning collaborative for pediatric providers to improve their management of children with asthma, such as diagnostic standards, having an action plan for the child, and so on. The Learning Collaborative was conducted by UPIQ (Utah Pediatric Partnership to Improve Healthcare Quality) and data were collected to look at provider practice change.

c. Interpretation of what the data indicate

The rate of hospitalization decreased from 16.3 in 2005 to 14.6 in 2006.

Recently data were released that identified several pockets of the state with higher than average asthma rates. The distribution of the areas with increased rates was puzzling with one community with a high rate adjacent to one having a much lower rate. Obviously more study is needed to identify the reasons for the discrepancy. The Governor has made the environment a high priority, especially air quality, so this will assist us in or efforts to reduce the need for hospitalizations. The continued members of the Utah Asthma Task Force will continue to meet and review the objectives and strategies in the hope to continue to reduce hospitalizations due to asthma and the overall burden of asthma within Utah.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	81.4	82.7	82.5	83.9	86.4
Numerator	24439	26128	26629	26977	18747
Denominator	30036	31605	32282	32137	21701
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Data from the CMS 416 for FFY 2007

Notes - 2006
Data from the CMS 416 for FFY 2006

Notes - 2005
Data from the CMS 416 for FFY 2005

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSCIs?

The reporting on this indicator has improved; however, it really doesn't measure the extent to which Medicaid children are getting regular periodic screenings. This would be a better indicator of the level of care a child receives.

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

Of concern is the fact that the number of physicians willing to accept Medicaid reimbursement rates has decreased. To mitigate the problem, the Medicaid agency contracts with local health departments for CHEC (Utah's EPSDT) outreach to assist families in accessing health care services. The local health departments also provide targeted case management services for Medicaid families that include education about the importance of the well child visits, especially for children under age one year, and assistance with referrals to needed health care services when appropriate. The local health departments get Title V funding to provide Prenatal to 5 nurse home visiting services which may include Medicaid families whose needs go beyond those covered through targeted case management services allowable under Medicaid rules. Title V will continue to work closely with Medicaid to develop better strategies to improve access to health care for infants.

c. Interpretation of what the data indicate

The percent of Medicaid enrollees under age one receiving at least one initial periodic screen has been increasing since 2002 from 81.4 percent to 83.9 percent in 2006. The increases may be indicative of a positive impact of efforts to improve access to care for infants on Medicaid. However, we have more work to do to ensure that all Medicaid enrolled infants have access to health care given that more than 16 percent did not receive an initial screen.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	58.2	89.2	97.1	97.4	96.8
Numerator	338	654	135	185	182
Denominator	581	733	139	190	188
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Office of Healthcare Statistics, CHIP, 2007

Notes - 2006
Numerator: HEDIS measure “Well Child Visits in First 15 Months” 2006
The data were obtained through a combination of Hybrid and Administrative procedures from the providers.
Denominator: Sample selected by the providers

Notes - 2005
Numerator: HEDIS measure "Well Child Visits in First 15 Months" 2005
The data were obtained through a combination of Hybrid and Administrative procedures from the providers.
Denominator: Sample selected by the providers

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSCIs?

The source for 2005 and 2006 data is the HEDIS data as reported by the CHIP participating health plans. In 2005 the CHIP health plans started utilizing a combination hybrid and administrative data collection methodology designed to better capture the needed information.

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

Regardless of the reason for the increase, we are very pleased to see the significant improvement in screenings among this population of infants. Lessons learned from the CHIP population might be applicable to infants on Medicaid to improve their periodic screening rates, although the low Medicaid reimbursement rates continue to limit access for to care for Medicaid children.

c. Interpretation of what the data indicate

This Health System Capacity Indicator has shown dramatic improvement. In 2002 only 53.5 percent of infants had received a periodic screen and in 2006, 97.4 percent received a service. The increases may be due to better reporting of information.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	76.6	78.8	78.8	82.2	82.2
Numerator	38108	39844	39844	43970	43970
Denominator	49766	50581	50581	53475	53475
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Vital Records birth data 2006, IBIS UDOH

Notes - 2006
Vital Records birth data 2006, IBIS UDOH

Notes - 2005
IBIS UDOH 2005

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSCIs?

Utah Medicaid for prenatal services has the lowest allowable level of eligibility for enrollment. Utah women must be at or below 133% of the federal poverty level to qualify for prenatal Medicaid. Because of this stipulation, many working poor women who may be eligible in most other states across the country are reduced to self pay for prenatal care affecting their entry into and adequacy of prenatal care. The restriction of prenatal Medicaid for U.S. Citizens only precludes our growing Hispanic undocumented pregnant women from receiving early and adequate care and there are a limited number of safety net providers to provide prenatal services to this needy population. The Reproductive Health Program contracts with the Salt Lake City Community Health Centers Inc. to provide prenatal services for unfunded pregnant women who reside within the city limits, but the funding is inadequate to cover the need.

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

We will continue to focus on several initiatives to continue to reduce the rate of women who receive inadequate prenatal care in Utah including; strategies to reduce the teen pregnancy rate and to promote safety net providers who will cover undocumented women and encourage them to receive an adequate prenatal care services among this target group. In addition we will continue to implement the Baby Your Baby media campaign which utilizes the "13/13" message, start prenatal care by your 13th week of pregnancy and get at least 13 visits. These messages are aired via television, radio and print in both Spanish and English.

c. Interpretation of what the data indicate:

According to Utah birth certificate data, during 2006, 82.2% of Utah women delivering a live birth received adequate prenatal care based on the Kotelchuck Index. There is room for improvement in this rate and in addition, we have groups of women who are at higher risk of not receiving an adequate number of prenatal care visits.

Among Hispanic women who delivered a live birth during 2006, 30% of women received less than adequate prenatal care compared to 13.4% of their non-Hispanic counterparts. This is likely due to the large number of undocumented Mexican immigrants residing in Utah who do not qualify for prenatal Medicaid. While our Hispanic Mothers are receiving some prenatal care, because they are uninsured and paying out of pocket for their care, they may be likely to skip visits.

Another high risk group for not receiving adequate prenatal care is our teen mothers. Among teen mothers, 30.6% received inadequate prenatal care compared to only 14.9% of adult women during 2006. This may be due to the high rate of unintended pregnancy among teens creating a situation where these young women do not realize they are pregnant until well into the second trimester and therefore do not avail themselves of early and adequate care.

The last group of women who have higher rates of inadequate prenatal care are those who have 3 or more previous live births. Among this group of women, 20.4% received inadequate prenatal care compared to 15% of women who have had 3 or less previous live births. This may due to several factors including, lack of time and/or daycare for children and/or a feeling that they're experienced with pregnancy and do not need as many visits.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	78.5	88.0	93.5	93.5	93.5
Numerator	110002	128196	150379	150379	150379
Denominator	140176	145683	160915	160915	160915
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Numerator: Fee for service claims were used to calculate the number of unduplicated children receiving a medical service provided by Medicaid and estimates of a service received using Medicaid HEDIS data.
Denominator: The number of children enrolled in Medicaid plus the proportion of children with no insurance who could have been eligible for Medicaid based on income for ages 1-18, were calculated using the data from the Utah Health Status Survey 2005.

Notes - 2006
Numerator: Fee for service claims were used to calculate the number of unduplicated children receiving a medical service provided by Medicaid and estimates of a service received using Medicaid HEDIS data.
Denominator: The number of children enrolled in Medicaid plus the proportion of children with no insurance who could have been eligible for Medicaid based on income for ages 1-18, were calculated using the data from the Utah Health Status Survey 2005.

Notes - 2005
Numerator: Fee for service claims were used to calculate the number of unduplicated children receiving a medical service provided by Medicaid and estimates of a service received using Medicaid HEDIS data.
Denominator: The number of children enrolled in Medicaid plus the proportion of children with no insurance who could have been eligible for Medicaid based on income for ages 1-18, were calculated using the data from the Utah Health Status Survey 2005.

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSCIs?

This indicator has shown steady improvement since 2002. In 2005 93.5% of potentially Medicaid-eligible children received a service compared to 78.5% in 2002. This steady increase in services received is very encouraging as it can be interpreted as evidence that Medicaid enrollment outreach efforts are paying off and the health care system has capacity for families to access care for their children.

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

Bureau of Maternal and Child Health staff participate in Medicaid enrollment outreach efforts through a community-based coalition that was formerly the Utah Covering Kids and Families Coalition. This Coalition makes recommendations to the Medicaid agency on how to streamline the eligibility process, how agencies can provide better coordination to lessen paperwork and verification requirements for families and how outreach efforts can be improved and made more effective.

c. Interpretation of what the data indicate

Bureau of Maternal and Child Health staff work with the targeted case management staff in local health departments to help improve coordination between health care providers and families and to ensure that families have information about their Medicaid benefits and know how to access care.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	45.2	47.2	48.8	51.2	51.2
Numerator	11231	12772	14127	14920	14920
Denominator	24863	27088	28943	29135	29135
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
The data are from Medicaid CMS 416 for FFY07

Notes - 2006
The data are from Medicaid CMS 416 for FFY07

Notes - 2005
The data are from Medicaid CMS 416 for FFY05

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSCIs?

The improvement in the percentage of children receiving dental services is, in part, due to the emphasis that the Oral Health Program (OHP) has placed on early childhood dental caries prevention and education as well as the need for early and regular dental visits. The OHP has collaborated with the Utah Oral Health Coalition in the development and implementation of a public awareness campaign emphasizing the benefits of early and regular dental visits for children.

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

The OHP has collaborated with staff in the UDOH Division of Health Care Financing (Medicaid) to expand current CHEC (Utah's EPSDT) outreach programs. Through these expanded efforts, outreach workers have provided a higher level of case management for children needing dental services. The CHEC dental case management system pilot, which was implemented in three local health departments, has been expanded into all local health departments. CHEC outreach staff are responsible for: 1) conducting outreach to encourage use of preventive and follow-up services; 2) educating children and parents about CHEC benefits and the importance of keeping appointments; 3) working with parents to help reduce barriers to accessing care such as transportation, childcare, language, etc.; 4) serving as liaisons with dental offices to recruit and encourage dentists to become Medicaid providers. In addition, Division of Health Care Financing staff has worked with dental office staff on billing and other issues to reduce identified barriers to care. The State Dental Director has been working with the Utah Dental Association Aces Committee to encourage dentists to see Medicaid eligible children to improve the percent receiving dental care. The Dental Director meets with members of local dental jurisdictions around the state to promote increased access for children to dental services.

The OHP has worked with the Utah Oral Health Coalition, Salt Lake Valley Health Department and United Way of Greater Salt Lake in the development and implementation of the "Sealant for Smiles" program. First and second grade students from Salt Lake County Title I schools are provided dental education, screened for dental disease and have dental sealants placed. Care is coordinated for those students who have dental needs. Plans are to take the sealant program statewide.

The OHP has collaborated with the Utah Oral Health Coalition and the Salt Lake Valley Health Department in developing oral health education materials/curriculum which will be used in elementary schools to increase awareness of good oral hygiene habits and the value of regular visits to the dentist.

c. Interpretation of what the data indicate

Data indicate that efforts to increase access to dental care for this population is working but that ongoing work is necessary to assure that Medicaid children have access to routine dental care.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	34.6	34.0	25.1	19.9	22.5
Numerator	1165	1155	895	742	919
Denominator	3366	3396	3569	3728	4089
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

Numerator: Unduplicated CSHCN number that has been specifically matched for the age range of 16 years and under. The numerator reflects CSHCN systems data for age matched for, SSN, name and date of birth.

Denominator: SSI for calendar year 2007

Notes - 2006
Numerator: Unduplicated CSHCN number that has been specifically matched for the age range of 16 years and under. The numerator reflects CSHCN systems data for age matched for, SSN, name and date of birth.

Denominator: SSI for calendar year 2006

Notes - 2005
Numerator: This is the first unduplicated CSHCN number that has been specifically matched for the age range of 16 years and under. The numerator reflects CSHCN systems data for age matched for, SSN, name and date of birth.

Denominator: SSI for calendar year 2005

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSCIs?

Lack of information about possible SSI eligibility may be lacking thus limiting application for eligibility and receipt of services.

A presentation this year at the Family Conference was about SSI benefits for children. The session provided information about eligibility factors for SSI, income and asset limits and how to apply for SSI for children.

- Continue to employ SSI Specialist for CSHCN.
- Update and refine DDS log Letter sent to each family.
- Translate the DDS log letter into Spanish.
- Continue data collection for CSHCN on SSI.
- Continue to educate CSHCN staff about SSI, DDS and Medicaid.
- Develop age appropriate transition brochures and disseminate them to our clients

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

In Utah, children who have SSI are generally eligible for Medicaid, although the application processes are separate. CSHCN encourages families to apply for Medicaid and, if eligible, because SSI/Medicaid allows children to access a broad array of services beyond those provided by CHIP coverage or through CSHCN clinics. Rehabilitation evaluation and treatment for children are usually provided by one of three tertiary pediatric care facilities: Primary Children's Medical Center, Shriner's Hospital and the University of Utah Health Sciences Center, or through private community health care providers. CSHCN clinics provide an initial developmental evaluation (especially in rural Utah) and assists families of these children with information and referral to needed therapy services. Preschool children 0 to 3 years of age who have moderate to severe disabilities receive early intervention services from the BabyWatch/Early Intervention, which children with disabilities 3 to 5 years receive services through the Utah Department of Education, Early Intervention Program. Children who are deaf and or blind receive intervention services through the Utah School for the Deaf and Blind, Parent Infant Program.

The CSHCN Bureau employs an SSI Specialist who works with the Office of Disability Determination Services (DDS). As a member of the Disability Determination Services Advisory Council, the CSHCN Specialist offers consultation to DDS policy and service administration and fosters the relations between SSI, DDS/Vocational Rehabilitation, and CSHCN. Additionally, DDS

sends referrals for all potential recipients to age 18 years, for the CSHCN SSI specialist to provide outreach and information about potential Medicaid eligibility, as well as information on other community resources.

The Specialist also provides information, referral and enabling services to individual families whose children have been denied disability status and need support with reconsiderations or hearings for SSI, Medicaid or CHIP eligibility. The Specialist is Spanish speaking and has a rich background in working with families who are also Spanish speaking. These English/Spanish Speaking families are referred to resources such as Utah Legal Services, Disability Law Center or other consulting staff in DDS.

CSHCN also to employ a transition specialist who provides training, consultation, and support to CSHCN Bureau staff and itinerant staff in the area of adolescent and young adult transition services. Staff training is provided on identification of potential candidates for SSI participation and increasing successful referrals of children. (See PM 6, Transition).

In FY 2009, CSHCN will continue to focus on the reporting of SSI coverage by parents and our clinicians. To continue to have intake staff ask each time a CSHCN client comes to clinic about the status of SSI eligibility. Our SSI specialist will keep the DDS log updated from the information Disability Determination Services send to CSHCN. When information is missing CSHCN will request to needed information to make the record complete. Then the informational letter will be sent out in a timely manner.

c. Interpretation of what the data indicate

Numerator data for this indicator come from the number of referrals from Utah's Office of Disability Determination Services (DDS) added to the unduplicated number of children receiving direct CSHCN clinic services/case management. These data indicate that for 2007, the percent of identified SSI beneficiaries who received rehabilitative evaluation services from the State CSHCN programs increased 13% from 2006.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2006	matching data files	8.8	6	6.9

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSCIs?

We know through analysis of Utah PRAMS and birth certificate data that women enrolled in Medicaid during their pregnancies have an array of risk factors that are also commonly identified at higher rates in women who have low birth weight babies. These risk factors include indicators such as lower levels of education, low socio-economic status, being unmarried, using tobacco before and during pregnancy, and being of racial or ethnic minorities.

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

Many of these risk factors are not amenable to Title V interventions; however those that are, e.g. tobacco cessation strategies, are being addressed through ongoing collaboration with the Medicaid and Tobacco Prevention and Control Programs.

c. Interpretation of what the data indicate

Data indicate that in comparing Medicaid to non-Medicaid populations, women enrolled in Medicaid fare far worse than their non-Medicaid counterparts. The percentage of low birth weight babies among Medicaid women was 8.8 percent compared to 6 percent in their non-Medicaid counterparts. The total rate of low birth weight babies in Utah during 2006 increased to 6.9%. All of these rates represent a slight increase from the previous year.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2006	matching data files	6.9	4.3	5.2

Notes - 2009
This percentage is based on the linked Medicaid eligibility file and Vital Record data, and may differ slightly from calculations based solely on Vital Record infant mortality data.

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSCIs?

Many factors related to health status of a population are not amenable to public health intervention. Utah has experienced an influx of undocumented Hispanics from Mexico in recent years. The increase in this undocumented and often uninsured population of women may be contributing to the increase in infant mortality due to perinatal conditions. Although the Reproductive Health Program provides a small amount of funding to the Salt Lake Community Health Centers to provide prenatal care to unfunded women, the need is greater than the funding will support.

The Perinatal Mortality Review process implemented by the Department's Reproductive Health Program provides an opportunity for identification of factors that might have influenced an infant death. Approximately 100 infant deaths due to perinatal conditions are reviewed by a committee of perinatal health care providers each year providing critical information about issues that are amenable to public health intervention. Unfortunately, we lack funding and capacity to implement many of the large scale interventions identified that may improve outcomes.

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

The Utah Department of Health's Perinatal Mortality Review Program reviews all infant deaths due to perinatal conditions to identify issues that are amenable to public health interventions. Infant birth, death and medical records are abstracted and cases are summarized and presented

to a committee of perinatal health care professionals who identify themes of issues for possible intervention. In approximately 30 percent of the cases reviewed, infants' mothers were enrolled in Medicaid for some part of their perinatal care.

c. Interpretation of what the data indicate

The infant mortality rate among Medicaid women was 6.9/1000 live births compared to 4.3/1000 in their non-Medicaid counterparts and an overall rate of 5.2/1000 live births. While all rates have increased from the previous years, the rate among Medicaid women increased more dramatically (21% vs. 7.5%) than for the non-Medicaid women. Many of the risk factors for infant mortality mirror those for low birth weight (LBW) . In fact, low birth weight is one of the largest contributing factors to infant mortality in Utah.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	matching data files	68.7	84.2	79

Narrative:

a. What has influenced the program's ability to maintain and/or improve the HSCIs?

The Department implemented an online application program in 2006, Utah Clicks where women can log on and complete a screening process that suggests what programs she and her family may qualify for. The application screens for Medicaid, CHIP and Baby Your Baby (Utah presumptive eligibility for prenatal Medicaid program) among others. The system has simplified and streamlined these application processes thereby allowing earlier enrollment so that women can have coverage for prenatal care services earlier in their pregnancies. The Department continues to promote the use of Utah Clicks among women of reproductive age, but also has Memoranda of Agreements with over 65 qualified providers who enroll women into the Baby Your Baby program in face-to-face encounters in communities across the state

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

The Department has been working with the Utah NBC affiliate to promote the importance of early entry into prenatal care and to raise awareness about presumptive eligibility (PE) for Medicaid for pregnant women. In addition, the Department has continued to promote Utah Clicks, the online application system that simplifies and expedites enrollment into prenatal Medicaid for pregnant women who qualify.

c. Interpretation of what the data indicate

The percentage of Medicaid women receiving care in the first trimester was 68.7% compared to 84.2% in their non-Medicaid counterparts and 79% for all women. This is an increase for

Medicaid women versus a slight decrease for their non-Medicaid counterparts. Utah PRAMS data indicate that among women who qualified for Medicaid during their pregnancies, 52.5% reported their pregnancies as unintended, compared to 25.1% of those insured privately and 43.6% of those uninsured. This higher rate of unintended pregnancies among prenatal Medicaid enrollees likely contributes to lower rates of entry into first trimester prenatal care as women may not have identified their pregnancies early enough in the first trimester to begin prenatal care services.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2006	matching data files	73.2	86.8	82.1

Notes - 2009
This percentage is based on linked Medicaid eligibility file and 2006 birth data. This linked data differs slightly from calculations made only using birth data (82.14% vs. 82.23%).

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSCIs?

The factors mentioned in regards to first trimester entry into prenatal care also affect the quantity of prenatal care visits as late entry prohibits a woman from achieving the recommended amount of visits.

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

As early pregnancy recognition is likely contributing to the low rate of the early and adequate prenatal care among Utah's Medicaid enrollees, the Department has been focusing on educating women of reproductive age about the importance of planning for pregnancy. Educational materials are distributed through the Reproductive Health Program and Baby Your Baby websites as well as at community health fairs that target low income women who would be eligible for Medicaid. The Perinatal Taskforce subcommittee on Preconception Health has also developed a reproductive life plan tool that encourages women to prepare for pregnancies. The tool is being disseminated via the Reproductive Health Program website and, if funding allows will be printed and distributed through family planning clinics across the state.

c. Interpretation of what the data indicate

Data indicate that only 73.2% of Medicaid women received an adequate number of prenatal care visits while 86.8% of their non-Medicaid counterparts received an adequate number of visits

which calculates into a state rate of 82.1% of Utah women receiving adequate prenatal care.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2007	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2007	200

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSCIs?

Advocates have garnered some support to get legislators willing to sponsor a bill to drop the asset test. However, to date this effort has been unsuccessful.

Although the eligibility level for the CHIP Program has not changed, the Program has had to close enrollment almost every year due to budgetary limitations. In the last several years, the Legislature has increased state funding for CHIP. The 2008 funding increase is hoped to be enough to keep CHIP on an open enrollment basis.

The 2007 Legislature allocated additional funding to Medicaid to cover the anticipated increase in eligible children due to the CHIP application process which starts with a determination of Medicaid eligibility.

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

It is very difficult to impact these numbers due to the factors that influence enrollment. The Department works with its partners, community-based organizations and advocates to reach out to individuals who may possibly be eligible for either program. The CHIP Program has been advertised on TV spots when enrollment is open.

c. Interpretation of what the data indicate

This HSCI has been constant since the two programs were started in the state. Medicaid has an additional eligibility requirement imposed on applicants - an asset test. The required asset test prevents an individual with some resources from being determined to be eligible. The state legislature controls the state funding that is required for both of these programs limiting the eligibility to their current levels.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**

pregnant women.		
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2007	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2007	 200

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSCIs?

See 6A

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

See 6A

c. Interpretation of what the data indicate

See 6A

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2007	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women		

Notes - 2009
Pregnant women are not covered under Utah CHIP program.

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSCIs?

Advocates have garnered some support to get legislators willing to sponsor a bill to drop the required asset test. However, to date this effort has been unsuccessful.

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

The Department works with its partners, community-based organizations and advocates to reach out to individuals who may be eligible for Medicaid prenatal. The Division of Community and Family Health Services administers the Baby Your Baby Presumptive Eligibility (PE) Program to ensure access for possible eligible women to apply for PE while waiting for determination of their Medicaid eligibility. With the implementation of UtahClicks, access to PE is easier and more convenient.

c. Interpretation of what the data indicate

This HSCI has been constant since the Medicaid prenatal program was first implemented. Medicaid has an additional eligibility requirement imposed on applicants - an asset test. The asset test prevents an individual with some resources from being determined to be eligible. The state legislature controls the state funding that is required for this program limiting the eligibility to their current levels.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	2	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2009

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSCIs?

Linkage of data systems with WIC has not been possible due to the rollout of a new poorly developed information system in March 2006. Much progress has been made on the functionality of the WIC Information system since its rollout, but there are still some areas of the system that require fixes before it would be possible to link data sets. Another complicating factor is that Utah is involved in a three-state Consortium for a new computer system expected to be rolled out in 2009. It is entirely possible that linking WIC data with other data sets will not be possible until the Consortium product is rolled out and functioning.

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

Linkages in general have improved in the past few years, as well as surveillance efforts. The Department conducts an annual Health Status Survey which provides additional data on the general population in the state. This dataset is often used for our work in MCH/CSHCN. The Data Resources Program just recently was able to link Hospital Discharge data with Vital Records data.

The state SSDI grant in part supports YRBS so that we have data on adolescents that can be used for the Block Grant Annual report and application.

c. Interpretation of what the data indicate

The Utah Department of Health has a well-developed Center for Health Data in which vital records data, survey data, hospital discharge data and other data are available. The Department has the benefit of excellent data staff that are able to link data sets, analyze the data, etc. Program staff then review the data for trends or factors associated with trends to determine what interventions might possibly impact the rates. All indicators are rated at the highest level with exception of vital records with newborn screening and WIC with vital records.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes
Youth Tobacco Survey	3	No

Notes - 2009

Narrative:
a. What has influenced the program's ability to maintain and/or improve the HSCIs?

After the 2001 YRBS administration, Utah ceased to conduct the YRBS with CDC funding due to a legislative mandate prohibiting the Utah State Office of Education from applying for CDC funding related to HIV prevention. To continue the YRBS, the Utah Department of Health funded the 2003, 2005, and 2007 YRBS administrations through a variety of sources, including Title V, SSDI. The YRBS was integrated into a larger biennial school survey project that also includes the Youth Tobacco Survey and a local substance abuse survey. The Bureau of Health Promotion at

the Utah Department of Health recently received a CDC grant to conduct the 2009 YRBS.

b. What efforts are being made by the program in developing new strategies for meeting the HSCIs?

The Department of Health, in collaboration with the State Office of Education, conducts the Youth Risk Behavioral Survey (YRBS) in schools in the spring of odd years.
The YRBS is conducted in conjunction with two other surveys, the Youth Tobacco Survey (YTS), and a local substance abuse survey. Utah's YRBS methodology follows CDC's requirements. Since the school and student participation rate has been above 60% for all survey years, Utah data has been weighted by the CDC. Utah will continue to administer the YRBS in conjunction with other state-sponsored school surveys to reduce survey cost, investigate and share strategies to achieve adequate participation rates with active consent, and reduce the survey burden on schools.

c. Interpretation of what the data indicate
Utah continues to have low rates of tobacco use among high school students.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The initial planning process for the FY2005-2010 needs assessment process included a review of the FY2000 process to determine its effectiveness in identifying needs for mothers and children in the state from a broad perspective. The review led us to realize that we needed to seek broader input on the needs of pregnant women, mothers, young children, adolescents and children and youth with special health care needs than we had obtained for the previous needs assessment. In our discussions, we decided to ensure that we had input from individuals representing a broader view of health needs and issues for mothers and children in the state, such as parents, including parents of children and youth with special needs, members from all advisory committees that relate to MCH or CYSHCN issues, as well as other stakeholders working with mothers and children in the state.

The lead staff in the Division of Community and Family Health Services developed a plan for the five-year needs assessment that included development of a survey for each of the MCH populations and health service or system issues, involvement of the MCH/CSHCN Advisory Committee and its separate subcommittees, review of the recommended priority areas identified by each of the subcommittees to determine the final priorities for the Title V efforts for FY2006-2010. Key staff in the Division also participated in an abbreviated CAST-5 process to identify areas in which the agency needs to develop additional capacity.

Division staff developed a key informant survey to solicit opinions on key health issues in four areas: mothers and infants; young children and adolescents; children and youth with special health care needs; and, health care services. Various staff and outside partners were included in the development of the survey to ensure that it reflected key issues for each of the MCH populations. Members of the State ICC were involved in the key informant survey to ensure that they had an opportunity to voice their concerns regarding children and youth with special needs. The survey was designed for on-line response, however, hard copies of the survey were sent to individuals for whom we had no email address. With the request for survey participation, we encouraged those we contacted to forward the survey information to anyone they thought might be interested in providing input so that we could obtain as many responses as possible. Numerous individuals in the state representing various components of the system, such as local health departments, community health centers, private providers, advocacy organizations, the Department's Ethnic Healthy Advisory Committee (which includes representation of the various ethnic and minority populations in the state), parents of children and youth with special health care needs, agencies working with mothers and children, various advisory committees that address issues relating to the three MCH populations, etc. were contacted to participate in the survey.

Division data staff tabulated the survey responses and sorted the issues by rank order in each of the categories mothers and infants; children and youth; children and youth with special needs, and health care service. Almost 700 individuals (694) were contacted directly to participate in the survey, with 411 responses returned for a response rate of 59% (based on the number directly contacted). The respondents may include others we did not directly contact since we had encouraged wide distribution of the survey. Of the responses received, 83% were on-line responses. Interestingly, the largest group of responders was parents comprising 22% of the responders, with local health department staff comprising the next largest group at 17%.

The results of the survey were as follows:
Health Issues for Mothers and Newborn Babies
Unplanned pregnancies
Obesity
Depression or Other Mental Health Problems
Closely Spaced Pregnancies

Poor Nutrition During Pregnancy

Health Issues for Children and Adolescents
Lack of Physical Activity
Obesity
After School Supervision
Teen Pregnancy
Depression or Other Mental Health Problems

Health Issues for Children and Youth with Special Health Care Needs
Lack of Physical Activity
Lack of Respite Care
Depression or Other Mental Health Problems
Transition to Adult Life and Self-Sufficiency
Lack of Child Care

Health Care Services Issues
Dental Insurance
Obtaining Financial Help for Health Care
Health Insurance
Services not Covered by Insurance
Dental Care

Input from a variety of partners, especially families, has been very helpful in guiding discussions among the three subcommittees of the MCH/CSHCN Advisory Committee to identify the state top priorities or unmet needs of Utah's mothers and children. The overall needs assessment process has afforded the state Title V agency, its staff and its partners to examine the current status of health of the state's population and the health system needs.

The top five issues for each category came as no surprise to the Title V staff, although the high ranking of lack of physical activity in the CSHCN area did result in some discussion, especially given that it was ranked higher than respite care.

The state Title V agency continues its work on these priorities as well as the National Performance Measures.

/2009/ We continue to see the priorities of the Division to remain the same. While we have made progress on some of these, such as mental health and cultural sensitivity, we still see the priorities as needing our attention and efforts to improve. We also are starting to look into the process for the FY11 Needs Assessment process so that we have enough time to plan and execute the process. We are not sure if we will use the process we used in the last needs assessment or if we will utilize another process. //2009//

B. State Priorities

The needs assessment process included a review of status on National and State Performance and Outcome Measures, as well as Health Status, Health Systems Indicators and health care systems in the state. This review assisted in identifying priority areas along with the top issues obtained from the key informant survey. This review assisted in identifying priority areas along with the top issues obtained from the key informant survey.

/2009/ The state met eleven National Performance Measures and four State Performance Measures. The Measures that we did not accomplish included the following areas: family partnership in decision-making for children with special health care needs; children with a

medical home; teen birth rate; children with sealants, and smoking among pregnant women. State Performance Measures that were not met included: uninsured women; intended pregnancy; prepregnancy weight; appropriate weight gain during pregnancy; and children with special health care needs in rural areas receiving services. The state has noted considerable shifting of the specific measures not accomplished from the previous years. We will examine these measures to determine reasons for not accomplishing the measures to develop programs plans to better address these issues. //2009//

For quantitative methods, staff reviewed demographic data, health system capacity data to identify gaps and health issues that were becoming increasingly concerning, such as asthma hospitalizations for young children; the disparity among Medicaid mothers related to entry into care, adequacy of care, low birth weight and infant deaths compared to non-Medicaid mothers; and, the low percent of Medicaid enrolled children who received dental services. Data capacity is strong in the Utah Department of health and has progressed to almost full capacity over the last several years.

Key Title V staff participated in an abbreviated version of CAST-V to evaluate the state Title V agency's capacity. The Title V Director, MCH and CSHCN Bureau Directors along with other key staff reviewed the elements of CAST-V to assess the Utah Title V agency's capacity needs. Overall the review indicates that Utah's Title V agency has much capacity and the elements that were noted as needing improvement really only reflect the desire to development these elements to a higher level. The elements are in place, but barriers may prevent staff from accomplishing as much as they would like. Overall, the agency has capacity for 21 of the 28 elements, with the remaining 7 elements needing improvement or further development. The seven elements included:

• Authority and funding sufficient for functioning at the desired level of performance --the challenges in this element include: inability to create new positions to address capacity needs due to legislative restrictions; restrictions on applying for grant funds if new positions are needed to carryout the grant; and limited state funds for grants that require non-federal match.
• Mechanisms for accountability and quality improvement --we have informal processes in place for quality improvement for many programs, but limited ability to implement quality improvement with contractors, such as local health departments. Programs providing direct services tend not to be receptive to quality improvement as it interferes with service provision.
• Formal protocols and guidance for all aspects of assessment, planning and evaluation cycle -- this element is one that we need to focus more on and develop staff capacity.
• Adequate data infrastructure --We have strong data support, but capacity needs to be built to better support data needs of the state Title V agency in its work, especially relative to ethnic and minority population data
• Other relevant state agencies --While the UDOH has strong collaborative relationships with many state agencies, the State Office of Education has been very difficult to engage in collaborative initiatives. With a new Executive Director, perhaps this will change for the better.
• Businesses --this is an area that the Division of Community and Family Health has embarked on to a certain degree, but needs further development.
• Ability to influence policy-making process --The Department has the ability to influence policymakers to the degree that is within the boundaries of state government roles and the Governor's agenda.

The Executive Director of the Department of Health has vast experience in government nationally which will greatly benefit public health and Title V in the state as he works to overcome challenges we face.

Division staff developed a key informant survey to solicit opinions on key health issues in four areas: mothers and infants; young children and adolescents; children and youth with special health care needs; and, health care services. Various staff and outside partners were included in the development of the survey to ensure that it reflected key issues for each of the MCH populations. Members of the State ICC were involved in the development of the survey to ensure

that they had an opportunity to voice their concerns regarding children and youth with special needs. The survey was designed for on-line response, however, hard copies of the survey were sent to individuals for whom we had no email address. With the request for survey participation, we encouraged those we contacted to forward the survey information to anyone they thought might be interested in providing input so that we could obtain as many responses as possible. Numerous individuals in the state representing various components of the system, such as local health departments, community health centers, Department's Ethnic Health Advisory Committee (which includes representatives of each ethnic and minority population in the state), private providers, advocacy organizations, parents of children and youth with special health care needs, agencies working with mothers and children, various DOH advisory committees that address issues relating to the three MCH populations, etc. were contacted to participate in the survey.

In addition to the priorities that emerged from the needs assessment process, the MCH Bureau sponsored State Perinatal Taskforce meetings to identify four priorities to work on over the next year or so. Of all the issues included in the selection list, four priority areas emerged:
Family planning
Low birth weight and prematurity
Barriers to prenatal care
Depression and other mental health issues

These four priorities correspond to the issues identified through the key informant survey. Members of the Taskforce have signed up for one of the four subcommittees to address each of the priorities. The subcommittees are developing strategies to address each of the priority areas.

The Title V leadership reviewed the survey results, the recommendations of the subcommittees to develop the state priorities. After some thoughtful discussion, the following were identified as the State Priorities for FY2005-2010 including the populations impacted:

1. Depression and mental health (mothers, children)
2. Obesity (mothers [pre-pregnant and weight gain in pregnancy], children)
3. Intendedness of pregnancy (includes short interpregnancy spacing)
4. Medical home (all)
5. Access to health care for women of childbearing ages and children (all)
a. Women of childbearing ages who do not have insurance
b. Rural health (all, especially CSHCN)
6. Oral health (all)
7. Transition and vocational rehabilitation (CSHCN)
8. Ethnic/cultural issues (all)
9. Genomics (all)

The Division will continue to explore information related to the nine priorities, especially the two issues for which we did not develop a state performance measure, ethnic and cultural issues and genomics. We chose not to develop state performance measures on these two priorities since they were added to the list after some discussion of the areas in which we need to work on, but were not yet ready to develop a state performance measure. The ethnic and cultural area is one that all programs in the Division need to address, but we found it difficult to identify a measure to achieve. We will continue to explore this area with the Department's Center for Multicultural Health. We want to develop strategies to address how we as the state Title V agency function relative to ethnic and cultural diversity.

Genomics is such a new field that we have yet to determine how to incorporate this developing area into our work. The Department has a Genomics Program that is new and just beginning to explore how it can assist other programs in their work. The Program is designed to highlight how genomics can impact public health practice. In June 2005, program staff met with staff from other programs to discuss strategies and directions for the future. The website is http://health.utah.gov/genomics/

The other seven priorities were expanded into nine state performance measures, which are:
1. The percent of women of reproductive ages (18-44 years) who are uninsured
2. The proportion of pregnancies that result in a live birth that are intended
3. The proportion of women who have a live birth reporting moderate to severe depression who seek
help from a doctor or other health care worker
4. The percent of women with normal prepregnancy weight who deliver a live born infant
5. The percent of women who deliver a live born infant with appropriate pregnancy weight gain
6. The percent of children who are at-risk for overweight and overweight
7. The percent of youth who report feeling so sad or hopeless almost every day for two weeks or more that they stopped doing usual activities during the prior 12 months
8. The percent of children 6 -9 years of age enrolled in Medicaid receiving a dental visit in the past
year
9. The percent of CSHCN children in rural areas receiving direct clinical services through the state
CSHCN programs

We reserved the tenth state performance measure for either genomics or ethnic and cultural issues, or for another issue that may arise in the next year or two.

This needs assessment effort has produced invaluable information about the needs of Utah mothers, infants, children, adolescents and children with special health care needs, including adolescents with special health care needs, that the Division and others will be able to utilize in planning improved services and programs to better address the populations served through these funds. Recognizing that the needs assessment is an ongoing process, Title V leadership will continue to monitor Utah's progress in the priority areas identified in the needs assessment process, including those that were not included in the final list. Each year as additional data become available, such as adequacy of prenatal care statistics, programs review the data and seek strategies to address the findings. We will continue to review data as it is available to assess needs of mother, infants, young children, school-aged children and youth, including those with special health care needs as we implement the plans for the coming five years.

/2009/ As we approach the next needs assessment, we anticipate starting planning for it in early fall. We need to identify the process we will use to ensure a broad range of input and perspectives so that the assessment is methodical and inclusive. We anticipate that we will spend some time reviewing what other states have done for their needs assessment to identify a process that will work for our state. In reviewing the current state priorities, it seems as though they remain problematic and that it will take more than five years to see a great deal of progress. //2009//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	98.5	98.5	99	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	51	410	841	403	403
Denominator	51	410	841	403	403

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	100	100	100	100	100

Notes - 2006
The number of identified cases has dropped since last year due to decreases in the cutoff levels for certain conditions (amino acids, CAH, etc.).

Notes - 2005
Data are from the program database.

a. Last Year's Accomplishments
The performance measure was achieved. The Performance Objective was 100% and the Annual Indicator was 100%.

The Newborn Screening Program (NSP) continued its surveillance and identification of children with congenital hypothyroidism, galactosemia, biotinidase, congenital adrenal hyperplasia, amino acid disorders, organic acid disorders and fatty acid disorders.

The NSP participated in discussions with the Genetic Advisory Newborn Screening subcommittee to look at expanding the number of disorders tested by the State. Major consideration was given to Cystic Fibrosis (CF). Information was gathered from other states, consultants, and families with children who were diagnosed with CF.

The expansion to 36 disorders continued. Workflows were modified, and protocols were instigated. Education of staff continued in understanding the new disorders, the impact on families and identified babies, and how to educate staff in the medical homes and families. The new software system user education continued, and changes were made to the system to improve its functionality. The HL7 system offered challenges in coordinating data between the Department of Health and an outside entity. IT staff on both sides worked closely together to improve and track the exchanges.

CSHCN continued to provide collaborative and financial support to the Metabolic Clinic. Families with children with the diagnosis of PKU or galactosemia were offered financial assistance through the Children with Special Health Care Services for Metabolic Clinic visits and, in the case of PKU, medical formula.

The NSP staff worked with families, the Utah Insurance Department, Medicaid, and private insurance companies to facilitate the billing and coding systems.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Utah continued with its surveillance and identification of children			X	

2. All newborns with confirmed results were referred to their medical home provider. Referrals to sub specialists were coordinated with the medical home. Data will be collected to verify the diagnosis and treatment.	X			
3. The NSP continued to work with the Hearing Screening Program and the Vital Records to match data using the Birth Record Number.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Newborn Screening Program continues its surveillance and identification of children for State mandated screening disorders. Collaboration continues among the Pediatric Department of the University of Utah, the Associated Regional and University Pathologist, Inc, and the DOH to provide testing of disorders and follow up.

The review of Cystic Fibrosis by the Newborn Screening Subcommittee of the Genetics Advisory Council should be completed and recommendations submitted to the Department of Health.

Newborn screening kits are being sold to all institutions of birth and lay midwives. Consultations and education with all providers, families and the general public will continue.

The Newborn Screening Program continues to collaborate with data integration and streamlining of data collection. It supports and facilitates the 'Medical Home' model of health care.

CSHCN continues to provide collaborative and financial support to the University of Utah's Metabolic Follow-up Clinic, which follows children with PKU and galactosemia.

c. Plan for the Coming Year

The Newborn Screening Program (NSP) will continue its surveillance and identification of children with congenital hypothyroidism (CHYP), galactosemia (GALT), hemoglobinopathy (Hb), biotinidase (BIOT), congenital adrenal hyperplasia (CAH), amino acid and acylcarnitine disorders. Care coordination and data tracking will be on going. Collaboration will continue among the Pediatric Department of the University of Utah, the Associated Regional and University Pathologist, Inc, and the DOH to provide testing of disorders and follow up.

Cystic Fibrosis will be added to expand the screening disorders from 36 to 37 in January 2009. The state Rule guiding the newborn screening process will be rewritten and approved by mid summer 2008. New equipment will be purchased, training of lab staff will be completed, and validation studies will be done prior to the implementation date. New follow-up protocols will be established in conjunction with a pediatric pulmonary consultant. Education materials will be developed and distributed in written form (handouts, newsletters, etc.) and state's website will be redesigned.

Newborn screening kits will be sold to all institutions of birth and midwives. Consultations with all providers will be available by phone or site visit. Consultations and education of families and the general public will continue.

The NSP will continue to collaborate with data integration and streamlining of data collection. Linking newborn databases through the Birth Record Number will continue. NSP will become a link in CHARM. It will support and facilitate the 'Medical Home' model of health care. NSP will work in conjunction with Birth Registry on their National Birth Defects Prevention Study project.

Collaborative and financial support to the University of Utah's Metabolic Follow-up Clinic, which follows children with PKU and galactosemia, will continue. NSP will work with families, the Utah Insurance Department, Medicaid, and private insurance companies to facilitate the billing and coding systems.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	63.7	63.7	63.7	65	65
Annual Indicator	63.7	63.7	63.7	63.7	55.1
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	52	53	54	54	55

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
The performance measure was not achieved. The Performance Objective was 65.0% and the Annual Indicator was 55.1%.

The performance measure was not achieved, due to changes in the CSHCN survey questions. The Performance Objective was 65 and the Annual Indicator was 55.1. The CMS grant ended in 2007 and Utah Family Voices applied and received a new MCHB Family to Family Health Information Center grant. This project will continue and enhance activities established through the original CMS grant. The Family to Family Health Information and Education and Information

Center will collaborate with various health, disability and advocacy organizations to support families of children and youth as well as young adults with special needs in accessing resources for health and related services across the lifespan.

A system of support for Latino families was developed in collaboration with the University of Utah School of Medicine Department of Pediatrics through a Bright Futures grant. Partnership efforts conducted focus groups with families whose primary language is Spanish to gain the family perspectives of their needs and issues. Through the data collected the partners implemented an ongoing support and information project with families/professional partnerships.

The CSHCN family advocate and staff from the Utah Family Voices Health Information Center have been and will continue to be a part of the faculty for the Utah Regional Leadership Education in Neurodevelopment Disabilities with Utah State University and the University of Utah. Through the University of Utah we continue to be a component in core curriculum for pediatric medical residents, nursing school, physical and occupational therapy students. This partnership gives a parent's expertise and experience in the areas of Family-Centered Care, Medical Home and a Day in the Life of a family and child with special health care needs.

The family advocate and other families participate on numerous (over 20) state-level workgroups, advisory committees, and training programs. We continually review the membership and representation on boards and committees to assess whether there is an increase in family or young adult representation. One place we have had a positive impact is reflected on the Advisory Committee for the Primary Children Medical Center (the only tertiary state and regional hospital for children) which has enhanced their efforts to include family input and provide family-centered care. The family representation has tripled in the last 6 months as hospital staff has made additional efforts to include families in remote locations using technology.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Successful grant application for Utah's Family-to-Family Health Information Center				X
2. Spanish support and education group for Latino families		X		
3. Family-centered care in core curriculum of health care professionals				X
4. Increased family involvement and compensation for MCHB funded activities				X
5. Increased representation of families on state and national level boards and committees				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The contract with LINCS (Liaisons for Individual Needing Coordinated Services) continues to provide advocacy and resource information for families and children attending rural CSHCN clinics. CSHCN continues to employ a part-time family advocate to provide families with resource and advocacy information. The family advocate also recruits and trains other parents to serve as mentors, and obtains the family's perspective and input for new grants, materials or projects. Families continue to be represented on numerous boards and committees.

A support system for Latino families has been developed in collaboration with the University of Utah School of Medicine Department of Pediatrics. This partnership conducted focus groups in Spanish to gain information on needs and issues. Through the data collected the partners have implemented a family/professional support and information project.

CSHCN and Family Voices will hold a Family Leadership retreat to bring together new parent leaders with other family leaders in the state to begin networking and integrating family support systems in the state and educate about the six core performance measures.

CSHCN supports the Annual Family Links conferences held in the Salt Lake, Southwestern and Southeastern areas of the state including the Navajo Nation. The CSHCN family advocate is part of the planning committee and will address the health care related issues of families with children and youth with special health care needs.

c. Plan for the Coming Year

Family advocacy, support and involvement will continue as a priority area for CSHCN. The Bureau will continue to employ the Utah Family Voices Director, part-time as a family advocate, to work directly with parents providing them with resource and advocacy information. The family advocate will recruit and train other parents to serve as mentors for families through various other projects and programs for children and youth with special health care needs. Family representation on numerous boards and committees will continue. A parent's perspective and input will be obtained when writing new grants, other materials or implementing projects.

In collaboration with Utah Family Voices and the Utah Parent Center we will continue to support the newly MCHB funded Family-to-Family Health Information and Education Center (F2F HIC). Through theses efforts CSHCN will help to provide the information and support to families of children and youth with special health care needs that they need to make informed decisions in order to receive quality health care, maximize treatment choices, and improve health outcomes. Provide information, training, and guidance regarding the care and needs of CYSHCN to health care and other professionals including those in local, state, and national agencies and organizations. Develop and implement strategies for collaboration between families of children and youth with special health care needs and health professionals. Conduct outreach, training, and information dissemination activities that are culturally and linguistically relevant to families, health professionals, schools, and other agencies on home and community based services and supports and help families assess their potential eligibility.

The contract with LINCS (Liaisons for Individual Needing Coordinated Services) will be continued in 2009. LINCS in conjunction with Utah Family Voices will identify, train, and provide compensation to local parents who will provide advocacy and resource information for families and children attending rural CSHCN clinics in their communities.

CSHCN will continue to support the Annual Family Links conferences. The conferences are planned to be held in the Salt Lake area, in the Southwestern and the Southeastern including the Navajo Nation. The CSHCN family advocate will continue to be part of the planning of the committee and will address the health care related issues of families with children and youth with special health care needs.

Family needs and satisfaction will be measured by completion of family satisfaction surveys by parents who have participated in CSHCN programs, including clinical, screening, and Baby Watch / Early Intervention programs. The needs from the family's perspective will be collected through the family advocate and the Family Voices Health Information Center throughout on-going activities including surveys and focus groups.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	55.9	55.9	55.9	60	60
Annual Indicator	55.9	55.9	55.9	55.9	52.2
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	49	50	50.5	51	51

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
The performance measure was not achieved, due to changes in the National CSHCN survey questions. The Performance Objective was 60 and the Annual Indicator was 52.2.

UISP/CSHCN staff collaborated with the University of Utah, Utah State University and Utah Family Voices on curricula development in resident training for pediatric and family practice physicians and the ULEND training program. CSHCN created The Medical Home Corner in the local chapter of the AAP newsletter Growing Times and contributed a quarterly article. Monthly topical Medical Home practice conference calls continued, as have quarterly newsletters (published also on the MedHome Portal) and monthly practice visits to all 21 practice teams. The Utah Family Voices director continued to provide training and support to all the family advocates in the practices. Families are paid a monthly stipend to continue their involvement as advocates.

UISP staff guided the Learning Collaborative curricula development and completed two full day learning sessions to 12 medical practice teams emphasizing two of the six core outcomes while including information on the other four. The first session, Early and Continuous Screening, focused on developmental delay, anxiety and depression. Session two focused on transitioning YSHCN to adulthood. Adult medical practitioners were recruited to participate in the transition learning session with pediatric practice teams.

Through the UISP, a Young Adult Leadership Council (YAC) was established. Families and young adults with disabilities were integral in planning and presenting at learning sessions. A

video was made of the young adult panel during the transition learning session and presented at the AAP national meeting on medical home, distributed to all of our medical homes, presented at several local meetings and posted to "You-Tube." It was subsequently subtitled for the hearing impaired.

Information on the MedHome Portal (www.medhomeportal.org) was expanded with the addition of a Newborn Screening module, including information on congenital hypothyroidism (CHYP), galactosemia (GALT), hemoglobinopathy (Hb), biotinidase (BIOT), congenital adrenal hyperplasia (CAH), amino acid and acylcarnitine disorders. Portal user testing is ongoing as the site is currently undergoing a home page redesign. Representatives of CSHCN, UISP, Family Voices and the YAC recommended strategies for improving the MedHome Portal site. The YAC also reviewed the transition module on the MedHome Portal. A project began with University of Utah medical students researching and writing abbreviated diagnosis modules, increasing their knowledge of the Portal. Representatives of CSHCN, UISP, Family Voices and the YAC recommended strategies for improving the MedHome Portal site.

CSHCN provided multidisciplinary clinics in 8 remote Utah locations. Ongoing efforts were made to include local Medical Home providers who serve children in these locations in both the evaluation and follow up process of the clinics. The UISP presented its new state plan to three communities and followed up with issues raised at meetings, to educate community partners about issues surrounding the six outcome measures, and obtain feedback on the plan, including local challenges, strengths and opportunities. YAC provided input into the summits, and helped identify community goals most relevant to successful transition strategies for youth with special health care needs.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. UISP/CSHCN staff collaborated with University of Utah, Utah State University and Utah Family Voices on curricula development in resident training for pediatric and family practice physicians and the ULEND training program.				X
2. CSHCN created The Medical Home Corner in the local chapter of the AAP newsletter Growing Times and contributes a quarterly article.				X
3. UISP staff completed two full day learning sessions to 12 medical practice teams on Early and Continuous Screening and transitioning Youth with special needs to adulthood.				X
4. Prepared a video of a young adult panel during transition learning session, added subtitles for hearing impaired, distributed it to all medical homes, presented it at local meetings and at national AAP meeting, and posted video on “You-Tube.”		X		
5. Information on the MedHome Portal (www.medhomeportal.org) has expanded with the addition this year of the 31 metabolic disorders that the state is now testing all newborns. User testing is ongoing as the site is currently undergoing a redesign.				X
6. Representatives of CSHCN, UISP, Family Voices and the YAC recommended strategies for improving the MedHome Portal site. The YAC also reviewed the transition module on the MedHome Portal				X
7. The UISP presented the new state plan designed to integrate				X

community services to meet the six MCH core outcomes to three communities and followed up with issues raised at those meetings				
8. YAC provided input into the organization of the summits, and helped to identify the community goals that are most relevant to successful transitions.				X
9.				
10.				

b. Current Activities

The Utah Integrated Services Project grant will be completed in 2008: CSHCN is identifying successful components and reorganizing to maintain the MedHome newsletter, the Transition team, monthly MedHome practice conference calls and practice site visits. A final learning session on Transition was held for the 12 practice teams. Full evaluation of the project will be completed. The YAC have evolved to be part of the new "Becoming Leaders of Tomorrow" grant, and are developing materials, training and plans to mentor other young adults in self-advocacy issues. The UISP Administrative team is being reorganized to include Utah Family Voices, University of Utah, Utah State University and CSHCN to continue interagency planning and activities to improve Utah's system of care for CSHCN and to continue spread of medical home. CSHCN is reorganizing to sustain successful medical home and integrated services grant activities. The University of Utah in collaboration with CSHCN is working with the state legislature to propose a bill to fund a pilot to look at benefits and Medicaid cost savings of providing a care coordinator to CSHCN. A final meeting of the community advisory group is being held and the group will be reorganized as consultants to the new executive committee. CSHCN developed a downloadable referral form on the newly designed CSHCN website, to be used between referring Medical Homes and the CSHCN clinics throughout Utah.

c. Plan for the Coming Year

In the last year of the Utah's Integrated Services Project, CSHCN is identified successful core components of the project and will be reorganizing staff and funds to maintain the efforts. Plans for 2009 are to sustain our current 21 pediatric practice teams, by continuing 1) Yearly site visits to sustain their efforts; 2) Monthly topic oriented phone conferences; 3) Quarterly newsletters and; 4) Expansion of the MedHome Portal. CSHCN staff will continue to provide technical support, train new office staff in the medical home process, and share community resources to enhance integration of community services at the local level. Additionally, CSHCN will continue to work with all Utah Medical Homes to create a process for Medical Homes to have more input into the evaluation process of their patients being seen in our CSHCN clinics, as well as improve the timeliness of evaluation results being sent back to providers. CSHCN staff and contract subspecialists will begin regular visits to the eight satellite site areas, to provide training to all interested local Medical Home providers.

Collaboration will continue between the Family Voices, CSHCN, University of Utah and Utah State University on the medical home website, all of their medical home projects, residency training and ULEND training. The Family Voices director will continue to provide time and expertise in the efforts to insure parental input and support to the parent partners in our medical home sites. The MH project coordinator will become the chair of the Utah Parent Center board of directors starting in September 08 to insure parental input in our projects.

The MedHome Portal home page will be redesigned to be more user-friendly to both medical providers and families. Plans are to include other states information on the portal. Service categories are being reformulated requiring all resources to be reassigned to the appropriate category.

The coordinator of our current Medical Home/Integrated Services Project has agreed to manage the expanding transition program. New brochures are planned for families and young adults and development of a transition section on the CSHCN website will be designed.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	57.2	57.2	57.2	59	59
Annual Indicator	57.2	57.2	57.2	57.2	59.5
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	59	59	59	59	59

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
The performance measure was achieved. The Performance Objective was 59.0 and the Annual Indicator was 59.5.

CSHCN provided outreach and education to families who may be eligible for Medicaid, CHIP and SSI. Families were informed of eligibility requirements, differences in programs and how to apply for the programs by CSHCN staff, the Medical Home/Integrated Services Project's web-portal and Utah Clicks, the on-line application process for numerous state programs including Medicaid and CHIP. A database was created this past year to identify SSI eligible children in Utah who may qualify for other health care programs. Outreach letters were sent in English and Spanish to inform families of Medicaid and CSHCN programs and possible eligibility.

CSHCN staff collaborated with the Utah State University, Center for People with Disabilities "Proyecto Prevencion" grant project. This project conducted a statewide needs assessment of Latino youth and adults with disabilities and their families to determine the barriers for obtaining the needed health care to prevent secondary disabilities, including insurance barriers. Top barriers for this population were insurance access, fear of non-citizenship issues, transportation,

and lack of interpreters and cultural sensitivity of providers. Additionally, CSHCN staff is active in the DOH Latino Health Advisory Board and the Center for Multicultural Health, both of which are addressing health care access issues for people of diverse cultural background.

CSHCN worked in collaboration with hospitals and other community organizations to help cover the cost of medical services for children who do not have access to public or private health insurance. Utah's CMS funded project, the Family-to-Family Health Information and Education Center, assisted families in finding resources and providing health-related information regarding accessing public and private health insurance. In June 2007, the Utah Family Voices applied for and was funded by MCHB through the Family Opportunity Act, to continue and enhance the Family-to-Family Health Information and Education Center. The coordination of efforts between CSHCN programs and Utah's Family-to Family Health Information Center has increased outreach and information regarding resources and paying for services for at-risk populations statewide.

Medicaid continued its contracts with CSHCN to perform administrative case management activities and the day-to-day delegated administrative activities for Utah's Technology Dependent/Medically Fragile Waiver program. As part of the administrative case management contract, CSHCN staff coordinates medical and other services for recipients and assist with outreach and recruitment of potentially Medicaid eligible children and families. The waiver program also provides care coordination and access to Medicaid and additional waiver services and supports for approximately 140 families per year.

CSHCN's Medical Director and Physical Therapist provided consultation and input to Medicaid in determining medical necessity for children up to 21 years of age through the EPSDT Expanded Services and Prior Authorization Committee. The committee meets bi-weekly to review documentation and requests for services and supports and decide if they meet medical necessity criteria.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provided Medicaid, CHIP and SSI outreach to potentially eligible families of CYSHCN.		X		
2. Provided access to Medicaid for families with technology dependent children through a Medicaid home and community-based waiver program.		X		
3. Provided resource information through the Medical Home web-portal and simplified program application processes through Utah Clicks.		X		
4. Supported Utah Family Voices in the establishment of a Family-to-Family Health Information and Education Center.				X
5. Provided consultation and input to Medicaid in determining medical necessity for children up to 21 years of age through the EPSDT Expanded Services and Prior Authorization Committee.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHCN continues outreach to families who may be eligible for Medicaid, CHIP and SSI, and worked with the Department of Workforce Services (DWS) as they assume the function of Utah Medicaid application for families to insure that workers are knowledgeable about "disability" Medicaid eligibility, as well as helping to monitor whether potentially eligible families of young children with disabled children are not applying for CHIP and Medicaid and why. CSHCN is collaborating with community organizations to cover the cost of medical services for "unfunded" children.

CSHCN is working with Medicaid to on the Utah's technology dependent waiver program. CSHCN participates in the Medicaid Prior Authorization Committee and the Medical Care Advisory Committee. In FY 08, CSHCN is working with Medicaid in reinterpretation of the Federal Medicaid Targeted Case Management rule, as it affects many CSHCN programs.

CSHCN participates in Utah Clicks, the on-line application for state programs. Medical Homes received health coverage training through brochures, website and direct training, as well as training about toward families whose children with disabilities are transition to adulthood. The Utah Family Voices (UFV) Family-to-Family Health Information and Education Center supports families through health-related information including accessing public and private health insurance. UFV and CSHCN supports parent advocates/partners in the Integrated Services Project's 13 new medical home practices.

c. Plan for the Coming Year

CSHCN will continue outreach to potentially eligible Medicaid, CHIP and SSI families, directly and through the Medical Home web-portal. Families will be encouraged to use Utah Clicks for on-line application to Medicaid, CHIP, Early Intervention and CSHCN programs. Open enrollment for CHIP will continue throughout this year. A database will be used to identify SSI eligible children in Utah and a letter will be sent in English and Spanish informing these families of their potential Medicaid and CSHCN program eligibility. The Med Home web-portal will continue to develop providing resources and information to support Medical Homes, families and other health-related providers. The Bureau will collaborate with hospitals and other community organizations to help cover the cost of medical services for eligible children who do not have access to public or private health insurance.

CSHCN will provide administrative activities for Medicaid's Technology Dependent/Medically Fragile Waiver program: CSHCN nurses will oversee statewide Medical eligibility, service authorization and care coordination for the program serving 140 families each year. CSHCN staff will also provide Medicaid administrative case management functions and document these activities through periodic time studies.

CSHCN will continue membership on the EPSDT Expanded Services and Prior Authorization Committee for Medicaid. The CSHCN Medical Director and Physical Therapist will review documentation and provide recommendations on service coverage for children with special health care needs. CSHCN will work collaboratively with Medicaid on other policy and program development when needed.

Through the MCHB funded Family-to-Family Health Information and Education Center, Parent Partners will respond to the needs of families through direct family-to-family support, assisting with access to health-related information including public and private health insurance, attending and presenting at conferences and workshops, and involvement with existing projects where parent input is vital. Utah Family Voices will collaborate with the Utah Parent Center and the Bureau of CSHCN to implement additional activities to reach and further expand parent partners in health care and involvement on all levels of state decision making. CSHCN will continue to provide representation on the Family-to-Family Health Information and Education Center advisory

committee.

CSHCN will monitor initiatives that affect health coverage and provide education to families when applicable. CSHCN staff will partner with the Family-to-Family Health Information and Education Center to monitor the Family Health Opportunity Act and other emerging programs. Utah's Governor has made health care coverage for all Utah children a state priority. Opening CHIP enrollment continuously this next year and by establishing an insurance pool for small businesses are two mechanisms that have already been implemented.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	79.1	79.1	79.1	82	82
Annual Indicator	79.1	79.1	79.1	79.1	86.2
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	82	82	83	83	84

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
The performance measure was achieved. The Performance Objective was 82 and the Annual Indicator was 86.2.

UISP/CSHCN staff collaborated with the University of Utah, Utah State University and Utah Family Voices on curricula development and implementation in resident training for pediatric and family practice physicians and the ULEND training program. CSHCN created a new column, The Medical Home Corner, in the local chapter of the AAP newsletter Growing Times and contributes a quarterly article. Collaboration with the state family practice physician's organization was established and articles of interest related to medical home are sent out via email and their newsletter to their members statewide. Bi-monthly meetings of the Integrated Services/Medical

Home Program multi-agency CSHCN advisory group gave guidance to the bureau's Learning Session curricula, to the community summit agenda, choosing the specific communities and which community members to include.

CSHCN provided access to community-based specialty care through nine statewide satellite case management and traveling clinics, serving 2953 children during the year. Specialists and ancillary service providers traveled to nine rural areas in Utah to provide multidisciplinary evaluations, diagnostic services, support to medical home providers, and follow-up as needed. Specialty areas included the following: developmental pediatrics, genetics, neurology, orthopedics, craniofacial, psychology, speech pathology, occupational/physical therapy, audiology, family advocates and transition specialists.

CSHCN provided case management to high-risk populations including children dependent on technology in Medicaid's Travis C. Waiver Program and for children in foster care through the Fostering Healthy Children Program (FHC). FHC assisted foster families to coordinate community care and collected and documented medical information for 4239 children placed in the foster care system. FHC worked with Utah Medicaid to improve Health Status Outcome Measures for children.

CSHCN worked with the Department's Center for Multicultural Health to improve access and collaboration with community providers of health, education, vocational rehabilitation, and health care coverage

Bureau programs augmented community clinical services, case management and capacity building efforts to enhance a coordinated system of care. The Newborn Follow-up Program (NFP) continued to provide assessment and developmental follow-up at selected sites, for approximately 1600 children meeting certain criteria leaving Utah newborn intensive care units.

The Baby Watch Early Intervention Program provided services to 6112 infants and toddlers with disabilities and families through 15 local programs statewide. BWEIP provided training and technical assistance to providers. BWEIP continued its effective use of the statewide database, BTOTS, which allows the program to monitor family and child outcomes in relation to BWEIP interventions. BWEIP instituted a Family Satisfaction Survey which will be conducted annually. Information from families will be analyzed by early intervention program site.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Information and resources were provided to primary care providers and families directly and through the MedHome web-portal.				X
2. The Utah Integrated Services Project collaborated with 12 primary care practices providing education and support activities to increase their knowledge of the community-based service system.				X
3. Utah's Family-to-Family Health Information and Education Center was established and provided parent-to-parent support and information on community resources and services.				X
4. CSHCN provided access to community-based specialty care through statewide satellite case management and traveling clinics.	X			
5. CSHCN provides case management to high-risk populations including children who are dependent on technology and		X		

enrolled in the Medicaid's Travis C. Waiver Program and for children in foster care through the Fostering Healthy Children Program (FHC).				
6. Bureau programs augmented community clinical services, case management and capacity building efforts to enhance a coordinated system of care.				X
7. Baby Watch Early Intervention Program provided multidisciplinary services to infants and toddlers with disabilities and their families through a statewide program; continued CAPTA outreach to children in Utah Foster Care.	X			
8. BWEIP augmented BTOTS database to monitor child and family outcomes.				X
9.				
10.				

b. Current Activities

CSHCN continues to provide access to community-based specialty care through statewide satellite case management and traveling clinics. CSHCN will provide case management to high-risk populations including children who are dependent on technology and enrolled in the Medicaid's Travis C. Waiver Program and for children in foster care through the Fostering Healthy Children Program (FHC). Bureau programs will continue to evaluate the service delivery system to increase efficiency, and assess for needed changes in case mgt. and clinical services.

Through the Utah Integrated Services Project (UISP) and the Medical Home project, CSHCN will continue to strengthen the community-based infrastructure for CSHCN. Despite the end of the MCH grant for UISP, the staff is currently reorganizing the structure to allow for the continuation of the efforts already implemented.

The Newborn Follow-up Program (NFP) continues to provide multidisciplinary clinics to NICU graduates and will collaborate in University research projects for this population. They will complete the first version of a new clinical database.

The Baby Watch Early Intervention Program (BWEIP) provides services statewide to infants and toddlers with disabilities and their families through 15 local programs. They will expand the use of the Baby and Toddler Online Tracking System (BTOTS) data for family and child outcome evaluation and will begin a prevalence rate study to determine if child find activities are effective.

c. Plan for the Coming Year

CSHCN will provide access to community-based specialty care through statewide satellite case management and traveling clinics. Specialists will travel to the rural areas in Utah to provide diagnostic services and follow-up. CSHCN will provide case management to high-risk populations including children who are dependent on technology and enrolled in the Medicaid's Travis C. Waiver Program and for children in foster care through the Fostering Healthy Children Program (FHC). The nurse case managers for FHC will continue to assist foster families to access health-related and community care and to collect and document medical information for children in the foster care system.

Representatives from University of Utah, Utah State University and CSHCN will continue develop and implement strategies to support the Medical Home portal. CSHCN will continue to strengthen the community-based infrastructure for CYSCHN. Utah's Family-to-Family Health Information and Education Center will provide parent-to-parent support and information on community resources and services. During this next year, the center will continue its focus on collaboration and sustainability by developing new family advocacy and interagency relationships with community-

based organizations at the local, state and national level.

Bureau programs augment community clinical services, case management and capacity building efforts to enhance a coordinated, community system of care. Due to flat state and federal funding for CSHCN clinics, the Bureau will closely evaluate the clinic delivery system, to increase efficiency, possibly combining or eliminating clinics. CSHCN programs will collaborate with the Department's Multicultural Health Center and other community cultural agencies to improve access and partner with community providers of health, education, vocational rehabilitation, and health care coverage.

The Newborn Follow-up Program (NFP) will continue to partner with the University of Utah to provide multidisciplinary clinics to NICU graduates. NFP will develop a clinical database to support the management of their multidisciplinary clinics. This database will then be customized to include other CSHCN clinical programs.

The Baby Watch Early Intervention Program (BWEIP) will provide services statewide to infants and toddlers with disabilities and their families through 15 local programs. BWEIP educates and provide technical assistance to their network of providers. BWEIP will expand the use of the Baby and Toddler Online Tracking System (BTOTS) data for family and child outcome evaluation. Collaboration with CSHCN clinical entities and CHARM will focus on implementing and expanding data sharing and the possible use of electronic medical records to bolster this enterprise. BWEIP will begin a prevalence rate study to determine if child find activities are effective.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective					
Annual Indicator	5.8	5.8	5.8	5.8	42.5
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	36	37	38	39	40

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
The performance measure was not comparable to 2001 data, due to changes in the National CSHCN survey questions. Based on the most recent 2005 CSHCN survey released in December of 2007, the Annual Indicator was 42.5.

In FY2007, the Bureau of CSHCN continued to promote and support transition services for young adults by continuing support for the Utah Integrated Medical Home website, providing access and information critical for successful transition to adult services. Through the Integrated Services/Medical Home Program, training on Transition Issues was provided to 22 Medical Home teams, a transition module was developed on the MedHome Portal and articles on transition to adulthood for CSHCN were published in the MedHome newsletters and in the Growing Times, newsletter for the Utah Chapter of AAP. CSHCN also provided support for the Young Adult Advisory Council, through the Integrated Services Grant: ten young adults participated during the year and received leadership training and mentorship. They participated in the project Learning Collaborative as presenters and as advisors. A video was made of the young adult panel during the transition learning session and presented at the AAP national meeting on medical home, distributed to all of our medical homes, presented at several local meetings and posted to "U-Tube." It was subsequently subtitled for the hearing impaired. Through the URLEND program, transition to adulthood training was provided to the 13 multidisciplinary trainees.

CSHCN continued to employ a transition specialist in FY2007 who provided direct transition planning to young adults with disabilities and their families in Blanding, Moab, Montezuma Creek, Price, Richfield and Vernal itinerant clinics: These services are especially important, as rural Utah presents significant challenges for families in successful transition into adult services for their children. In Salt Lake City, the transition specialist provided direct services to young adults and their families at Orthopedic Clinics, ABLE Clinics and Community Based Services Clinic. Both in rural sites and Salt Lake City the transition specialist coordinated with local health department staff, health and mental health providers, educational institutions and other agencies.

In addition to onsite consultations, phone consultations, written and email correspondence and other supports were available to young adults and their families. The transition specialist was also available to physicians, other community referrals and agencies for needs assessment and transition planning. The transition specialist maintained current information for young adults and their families with regard to the entire spectrum of transition from pediatric services and programs to adult services and programs. This information was available through consultation and through the Medical Home Portal website.

In FY 07, a new transition team was established which included an SSI specialist who is a Spanish speaking social worker. He supported Latino and non-Latino young adults and their families in accessing Social Security, Medicaid and other community services. He also collaborated with the Center for Multicultural Health and the Latino Health Advisory Committee in providing transition information and support to the Latino young adults with disabilities.

CSHCN promoted other collaborative efforts in the area of transition, working with the various State and Federal agencies, including: Medicaid, Division of Services for People with Disabilities, the Utah State Office of Education, Vocational Rehabilitation and the Social Security Administration and other community programs. CSHCN continued to work to transition young adults with special health care needs and improve the health of the state's special needs population through collaboration with the Utah State University Center for Persons with Disabilities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided on-site transition services for young adults and their families at rural itinerant clinics sites. Phone consultation, written and email correspondence, and other supports continued to be available throughout the state.	X			
2. Provided on-site transition services for young adults and their families for CSHCN bureau programs based in Salt Lake City via in person appointments, telephone conference calls and written and email correspondence.	X			
3. Telephone consultation, written and email correspondence continue to be available throughout the state to physicians and community referrals from agencies and programs for needs assessment and transition planning.	X			
4. Maintained current resource information for adult services and programs.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The CSHCN transition specialist provides transition planning to young adults with disabilities and their families in Salt Lake City and itinerant clinics, as well as consultation to physicians and other providers. The SSI specialist on the transition team, a Spanish speaking social worker, supports Latino and non-Latino young adults and their families in accessing Social Security, Medicaid and other community services. He collaborates with the Center for Multicultural Health and the Latino Health Advisory Committee in providing transition information and supporting Latino young adults with disabilities. This year, the team wrote three new English and Spanish transition planning brochures, available on the MedHome and CSHCN websites. The team maintains current information on transition from pediatric to adult services and programs. The transition specialist and Workability presented and videotaped Supported Employment training for young adults with disabilities and their families. The transition team will also present at the Utah Education Conference. CSHCN also provides support for the Young Adult Advisory Council, through the Integrated Services Grant. CSHCN also participates in the Regional Leadership Regional Education in Neurodevelopmental Disabilities (RLEND) project in transition training. CSHCN continues to recruit and train family practice providers and Pediatric/Internal Medicine providers to whom transitioning CYSHCN can be referred.

c. Plan for the Coming Year

In FY2009, the CSHCN transition specialist will continue to travel to nine rural itinerant sites to provide transition planning to young adults and their families. Young adults and families in CSHCN Orthopedic and Pediatric clinics in Salt Lake City will continue to be served by the transition specialist. The transition specialist will work with local health departments, health and mental health providers, educational institutions and other agencies in this process.

Additional educational training opportunities will be offered, similar to the Utah Supported

Employment Project workshop for young adults and their families along with medical providers both locally and when possible through taping or Telehealth at itinerant clinic sites. Also, CSHCN is negotiating with Utah Medicaid Improvement Grant, "Workability" to be included in their upcoming renewal grant. CSHCN will provide training to Medical Homes on options for employment and Medicaid for young adults with disabilities. The CSHCN director will continue to participate in the Vocational Rehabilitation Council, the Utah Developmental Disabilities Council and the Workability Partnership committee, to address system issues of young adults transitioning to adulthood.

The transition team will update current information and provide new information and resources for the transition section of the CSHCN website. This will include the spectrum of transition from pediatric services and programs to adult services and programs. The Transition team will work with community partners to develop a comprehensive plan for the Bureau for provision of service for Transition to Adulthood.

The SSI/Medicaid specialist, who is a Spanish speaking social worker, will continue to support Latino and non-Latino young adults and their families in accessing Social Security Medicaid and other community services. He will also facilitate the translation of new transition materials to Spanish. He will continue to collaborate with the Center for Multicultural Health and the Latino Health Advisory Committee in providing transition information and support to Latino young adults with disabilities. Additionally, the CSHCN Bureau director will work with the newly formed DOH Multicultural Workforce Development task force, to develop a comprehensive plan for recruitment and retention of DOH employees from varied cultural, ethnic and linguistic backgrounds, including adults and youth with disabilities.

In FY2009, the Bureau of CSHCN and MedHome Portal website administrative team will work with the Utah Integrated Services Project, Young Adult Leadership Council to refine the transition module. Through their consultation, the Portal will better reflect the issues and resources that are pertinent to young adults.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	78	80	80	80	80
Annual Indicator	78.8	71.1	74.1	74.1	80.4
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	85	85	85	85	85

Notes - 2007
This measure does not have a numerator or denominator because it is taken from CDC's 2007 National Immunization Survey (NIS) which is only available at the state level as a percentage.

Notes - 2006
This measure does not have a numerator or denominator because it is taken from CDC's 2005 National Immunization Survey (NIS) which is only available at the state level as a percentage.

Notes - 2005
This measure does not have a numerator or denominator because it is taken from CDC's 2004 National Immunization Survey (NIS) which is only available at the state level as a percentage.

a. Last Year's Accomplishments
The performance measure was achieved. The Performance Objective was 80.0% and the Annual Indicator was 80.4%.

Staff in the Utah Immunization Program (UIP) worked with all stakeholders to ensure that the children were up to date on age appropriate immunizations by encouraging the parents to obtain the immunizations at their child's medical home where possible. No unique surveys were developed or administered to parents to assess parental attitudes about immunizations and barriers to immunizations, but routine surveys were completed by parents at local health departments when personal exemptions were requested for school aged children.

Outreach and enrollment activities were continued by the Immunization Program to provide training and technical support for the Utah Statewide Immunization Information System (USIIS) to users at all levels including coordinating quarterly regional user groups. Private provider enrollment reached 175, falling short of our goal by 25 providers. Staff turnover has limited our ability to recruit additional providers. Providers were encouraged to use the Web application, WebKIDS, and to actively transfer immunization information to USIIS during enrollment and routine VFC site visits.

Over 200 CASA/AFIX assessments were completed during FY07 by UIP staff. By the end of the year we had 341 providers enrolled in VFC, exceeding our goal of 320. Increased emphasis was placed on monitoring storage and handling during site visits and workshops/conferences. Provider staff was required to complete storage and handling training before VFC vaccine was shipped; when errors were made additional training was provided and vaccine orders were withheld until issues were resolved. A learning collaborative and curriculum were developed with the Intermountain Pediatric Society to improve provider rates. Mentor physicians were recruited into the collaborative and trained regarding intervention practices and program expectations.

The UIP collaborated with the National Immunization Program as one of the national kick-off states to recognize National Infant Immunization Week. The UIP continued its collaboration with private sponsors to support the "Immunize By Two" campaign through TV and radio spots. An additional radio campaign focused on the southwestern part of Utah to increase immunization awareness. The Utah Immunization Program continued its partnership with the Hallmark Greeting Card Program, sending congratulatory cards to parents of two-month old infants and encouraging them to begin immunizations by two months of age. Immunization staff was available to provide support and consultation in the area of coalition development. Limited funds have been distributed to local coalitions to provide education and support development.

Pilot projects were started in local WIC office to introduce a one-month voucher program that screened for immunizations. If the child was not up to date, they received one month of WIC vouchers and were referred to their primary care provider for vaccines. Upon receipt of needed vaccines, the client was then provided three months of vouchers.

VFC tear off sheets were developed and distributed to providers in response to the ethnic survey and parent focus groups that revealed parents don' t know what VFC is. All immunization literature was translated into Spanish for distribution to the Hispanic population. The Utah Immunization Program advertised and maintained an article in the Hispanic Yellow Pages to provide current immunization information. The UIP completed a new printing of A Family's Guide

to Vaccine Safety for Native American populations. Work continued with the liaison with Native American populations in Medicaid. Through her efforts the tribes received timely flu vaccine information and pandemic planning information. One barrier to increased immunizations among minority populations is the limited data available statewide on race and ethnicity. The mobile immunization clinic (Care-A-Van) held 61 clinics throughout Utah.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 75 private providers enrolled in USIIS				X
2. Over 200 CASA/AFIX assessments conducted				X
3. 341 providers enrolled in VFC program				X
4. Learning collaborative created with the Intermountain Pediatric Society				X
5. Continued Immunize By Two media campaign			X	
6. Completed a new printing of A Family's Guide to Vaccine Safety for Native American populations			X	
7. The mobile immunization clinic (Care-A-Van) held 61 clinics throughout Utah	X			
8.				
9.				
10.				

b. Current Activities

Immunization staff participates in coalitions to provide support and consultation. A Program Manual was developed and reviewed by LHD Nursing Directors, and will be posted online.

USIIS was transferred to the same division as the UIP, created a strategic business plan, and developed HL7 capability. Testing is underway for 2 way messaging with EMRs. There has been a large push to enroll schools in USIIS which has resulted in 128 new enrollments. A USIIS satisfaction survey was completed by 153 clinics with 91.5% indicating that they were satisfied with the program.

The UIP actively recruits private providers through contacts with Medicaid and local chapter of the AAP. CASA/AFIX assessments are conducted in provider offices. Fourteen practices are participating in the UPIQ quality improvement project.

The UIP continued its collaboration with private sponsors to support the "Immunize By Two" campaign. Two new TV spots were created. A supplemental radio campaign continued in the southwestern region of Utah. The UIP continued its partnership with the Hallmark Greeting Card Program, sending congratulatory cards to parents of two-month old infants and encouraging them to begin immunizations by two months of age.

The WIC One Month Voucher program is being fully implemented at the Salt Lake Valley Health Department. To date, we have scheduled 30 mobile immunization clinics (Care-A-Van).

c. Plan for the Coming Year

The Utah Immunization Program (UIP) will develop and implement a comprehensive quality improvement program to assist providers in increasing immunization coverage levels using all aspects of the AFIX strategy. The UIP will monitor provider use of public vaccines through Doses

Administered reporting to enhance accountability. The UPIQ project will continue to assist in and support best practices to improve immunization rates in Utah; coverage rates of participating clinics will be tracked and reported. A VFC provider satisfaction survey will be developed and administered. Findings from this survey will be utilized to improve coverage and recruit new enrollees.

The UIP and Utah Statewide Immunization Information System (USIIS) will develop a method to use USIIS to assess immunization coverage levels statewide, regional, and at the provider level. Outreach, enrollment and training activities for USIIS will be supported by the UIP to all USIIS users. The UIP will increase USIIS public & private provider enrollment by 10%. The UIP will assist USIIS with the transfer of race and ethnicity data from vital records.

The contract with Clear Channel Broadcasting Association and partners to sustain the, "Immunize by Two", media campaign will be reviewed and updated. We will continue Hallmark Greeting Card Program. Two provider education conferences/workshops will be planned and implemented in collaboration with the Northern Utah, Greater Salt Lake and Utah Audit Immunization coalitions. The UIP will develop and disseminate information packets for local health departments, community health centers and coalitions to promote national health observances. Collaborations will occur with provider organizations such as Intermountain Pediatric Society and the Utah Medical Association to conduct two provider education trainings.

Our program goal is to provide age/culturally appropriate educational/informational immunization materials to consumers. All program materials will be available in English and Spanish. The UIP will promote the VFC Program with articles in minority magazines and newspapers. We will provide education and information through media sources that target ethnic populations. Collaborations with federal, state and local Indian Health Services (where appropriate) to provide immunization information among ethnic populations (especially American Indians) will be initiated. Results of "2007 Qualitative Ethnic and Racial Health Project" will be distributed to all constituents.

The mobile immunization clinic activities (Care-A-Van) will continue, and the UIP will promote the Care-A-Van among minority organizations and communities through collaboration with grass roots minority organizations. Changes to Care-A-Van will be made based on the results of the 2007-2008 parent and host surveys. The State WIC program will continue support of immunization activities in local WIC clinics.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	17	16.5	16	14.8	15.7
Annual Indicator	16.0	14.9	15.7	15.7	16.6
Numerator	920	854	917	917	981
Denominator	57349	57505	58374	58374	58992
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

	2008	2009	2010	2011	2012
Annual Performance Objective	16.5	16.4	16.3	16.3	16.2

Notes - 2007
Numerator: Office of Vital Records and Statistics. UDOH. 2006
Denominator: IBIS Population estimates for 2005

Notes - 2006
Numerator: Office of Vital Records and Statistics. UDOH. 2005
Denominator: IBIS Population estimates for 2005

Notes - 2005
Numerator: Office of Vital Records and Statistics. UDOH. 2004
Denominator: IBIS Population estimates for 2004

a. Last Year's Accomplishments
The performance measure was not achieved. The Performance Objective was 15.7 and the Annual Indicator was 16.6.

The Maternal and Child Health Bureau continued to oversee MCH Title V federal funding for Abstinence-only Education Program. The Adolescent Health Coordinator carried out oversight and technical assistance to funded community-based projects, which promoted abstinence from sexual activity, tobacco, alcohol and other drugs among youth aged 9-19 years through a variety of methods that were sensitive to community needs. Many of these projects partnered with school districts to implement maturation and abstinence-based programming. Health care providers, service providers, religious and community leaders were targeted to encourage promotion of abstinence in their work with youth and parents. Each project had a parent component to encourage parents to regularly discuss abstinence with their children.

The Adolescent Health Coordinator continued to oversee the Utah Adolescent Health Network, which continued to focus on teen pregnancy prevention and STD prevention. The network was comprised of two subcommittees, Teen Pregnancy Prevention and STD Prevention. The Substance Abuse and Mental Health (as it relates to Teen Pregnancy) subcommittee was disbanded but its members were incorporated into the other two subcommittees which included substance abuse and mental health as part of their discussions. The two subcommittees continued to work on reaching the Utah State Teen Pregnancy Prevention Goal: By the year 2015, Utah will achieve a 20% decline in the pregnancy rate among girls between the ages of 15-19. The subcommittees monitored, analyzed and released state data as it pertained to this goal. They also developed goals and objectives to assist in reaching the goal. The STD subcommittee held press events, free HIV and STD screening weeks, and continued to provide awareness and information to schools. The TPP subcommittee was awarded a $15,000 grant to pilot a CDC parent program (Parents Matter). This program will be implemented in FY08, however much of the planning was completed during FY07. The pilot will target Hispanic parents who have children between the ages of 9-12. Parents Matter is an evidence-based intervention that promotes positive parenting and effective parent-child communication on sexual topics and sexual risk reduction.

The Reproductive Health Program continued to provide contract oversight for the MCH Title V Funding contracted to the Teen Mother and Child Program at the University of Utah for the provision of supportive, age appropriate prenatal and pediatric care to teen mothers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Oversaw MCH Title V federal funding for Abstinence-only Education Programs				X
2. Technical assistance to funded Abstinence projects				X
3. Monitored, analyzed, and released Utah teen pregnancy and STD data				X
4. Provided oversight of the Adolescent Health Network				X
5. Planned for the STD pilot of the Parents Matter Program				X
6. Provided free testing weeks for HIV and other STDs	X			
7. Provided contract oversight for the Teen Mother and Child Program funding				X
8. Provision of age appropriate prenatal and pediatric care to teen mothers	X			
9.				
10.				

b. Current Activities

The MCH Bureau will continue to oversee the Title V federal funding for State Abstinence Education Program. The Adolescent Health Coordinator will continue to provide oversight and technical assistance to the current community-based projects, which promote abstinence from sexual activity, tobacco, alcohol and other drugs among youth aged 9 - 19 years.

The Adolescent Health Coordinator will oversee the Utah Adolescent Health Network, which will focus on teen pregnancy and STD prevention. The Network will continue to work on reaching Utah's Teen Pregnancy Prevention Goal: By the year 2015, Utah will achieve a 20% decline in the pregnancy rate among girls between the ages of 15-19 (Baseline year, 2003).

The Teen Pregnancy Prevention subcommittee of the Utah Adolescent Health Network will collaborate with the Centers for Disease Control to pilot a parent program. This program is an evidence-based intervention designed to promote effective parent-child communication about sexuality and sexual risk reduction for parents of 9-12 year olds.

The Reproductive Health Program will continue to provide contract oversight for the MCH Title V funding contracted to the Teen Mother and Child Program at the University of Utah for the provision of age appropriate prenatal and pediatric care to teen mothers. Contract specifications will include the prevention of repeat teen pregnancies and development of strategies to reduce the increasing rate of repeat teen pregnancies.

c. Plan for the Coming Year

The Maternal and Child Health Bureau will continue to oversee the Department of Health and Human Services (HHS), Administration for Children and Families (ACF), Title V federal funding for State Abstinence Education Program. The Adolescent Health Coordinator will carry out oversight and technical assistance to funded community-based projects, which promote abstinence from sexual activity, tobacco, alcohol and other drugs among youth aged 9 - 19 years through a variety of methods that are sensitive to community needs. Many of these projects will partner with school districts to implement maturation and abstinence-only programs. Health care providers, service providers, religious and community leaders will be targeted to encourage promotion of abstinence in their work with youth and parents. Each project will also have a parent component to encourage parents to regularly discuss abstinence with their children.

The Adolescent Health Coordinator will continue to oversee the Utah Adolescent Health Network, which will continue to focus on teen pregnancy prevention. The network will continue to be comprised of two subcommittees. Those subcommittees are Teen Pregnancy Prevention and STD Prevention. Both subcommittees will continue to work on reaching the Utah State Teen

Pregnancy Prevention Goal: By the year 2015, Utah will achieve a 20% decline in the pregnancy rate among girls between the ages of 15-19 (Baseline year, 2003). The subcommittees will continuously monitor state data as it pertains to this goal. They will also develop and revise goals and objectives to assist in reaching the goal. The network will select new chairs for each of the subcommittees.

The Teen Pregnancy Prevention subcommittee of the Utah Adolescent Health Network will utilize the Centers for Disease (CDC) Parents Matter program to plan and implement parenting programs within the community. This program is an evidence-based, parent intervention designed to promote positive parenting and effective parent-child communication about sexuality and sexual risk reduction for parents of 9-12 year olds.

The Reproductive Health Program will continue to provide contract oversight for the MCH Title V Funding contracted to the Teen Mother and Child Program at the University of Utah for the provision of supportive, age appropriate prenatal and pediatric care to teen mothers. Collaboration with the program to assure a focus on prevention of repeat teen pregnancies will take place to identify strategies to address this increasing rate.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	49.9	49.9	52	50	45.1
Annual Indicator	49.9	49.9	49.9	45.1	45.1
Numerator	252	252	252	155	155
Denominator	505	505	505	344	344
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	45.1	45.1	45.1	50	50

Notes - 2007
Utah Oral Health Survey 2005, Oral Health Program
CFHS, UDOH

Notes - 2006
Utah Oral Health Survey 2005 Oral Health Program
CFHS, UDOH

Notes - 2005
Utah Oral Health Survey 2000 Oral Health Program
CFHS, UDOH

a. Last Year's Accomplishments
The performance measure was not achieved. The performance Objective was 50% and the Annual Indicator was 45.1%.

During FY06, CFHS Oral Health Program (OHP) promoted sealants through screening and

referral activities, supported direct delivery of sealants at the local health department level, and education/awareness programs among dental professionals, pediatricians and the public. The OHP concentrated on training local health departments on screening, sealants and referring procedures for children attending high risk elementary schools in their communities.

The OHP supported and provide technical assistance in collaboration with the Salt Lake Valley Health Department (SLVHD) for the United Way of Salt Lake Michael Foundation funded "Sealants for Smiles" school-based preventive dental program. More than 1,500 children were screened and over 3,000 sealants placed in FY07 on low-income uninsured and Medicaid insured children.

The OHP also supported and provided technical assistance to sealant placement projects for low-income uninsured and Medicaid insured children, coordinated and conducted by Dental Hygiene Programs at Weber State University, Salt Lake Community College, Utah Valley State College and Dixie College. Sealant Projects in the Salt Lake Valley Health Department, Weber-Morgan Health Department, Utah County Health Department and Southwest Utah Health Department included, in addition to health department and school personnel, volunteer dental hygienists, dentists and dental assistants. A manual outlining a sealant project protocol/model was developed through a cooperative effort between OHP and SLVHD and used to assist additional local health departments and communities in implementing sealant projects.

The OHP, in collaboration with other state agencies and organizations such as the Utah Oral Health Coalition, Medicaid (EPSDT), CHIP and Community Health Center Dental Clinics, promoted oral health prevention including sealant utilization to the public. Other activities included making presentations and providing educational material regarding the benefits of sealants to dental professionals, pediatricians and other health care providers who have opportunities to promote and refer children for sealants.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Have provided technical assistance for local health department to form local Oral Health Task Forces.				X
2. Developed strategies to reduce percentage of children with untreated dental decay and increase numbers of those with dental sealants through the Sealant for Smiles Program by using the findings of a statewide survey of 6-8 year old children.				X
3. Supported and provided technical assistance for free sealant projects to low-income and underinsured 6-8 year olds in Salt Lake, Davis, and Tooele Counties.				X
4. Supported the prevention and education activities of the Utah Oral Health Coalition.				X
5. Worked with Sealant for Smiles in modifying the program developed by the American Association of Community Dental Programs called “Seal America” and used as a guide to promote dental sealant programs at the community level.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During FY07, CFHS Oral Health Program (OHP) is promoting sealants through screening and referral activities. The OHP is promoting education/awareness programs among dental professionals, pediatric health care providers and the public. The OHP is supporting and provide technical assistance in collaboration with the Dental Select's "Sealant for Smiles" school-based preventive dental program. The Program supports the development and implementation of additional sites for "Sealant for Smiles" programs in Tooele, Summit and Salt Lake Counties. It is anticipated that more than 3,000 children will be screened and over 5,000 sealants placed in FY07 on low-income uninsured and Medicaid/CHIP insured children. The OHP also supports and provides technical assistance to sealant placement projects conducted by dental hygiene programs throughout the State. Other activities include making presentations and providing educational material regarding the benefits of sealants to dental professionals, pediatric health care providers and others who have opportunities to promote and refer children for sealants.

The program is following grant announcements for oral health funding opportunities that will allow the program to work further on these issues.

c. Plan for the Coming Year

During FY08, CFHS Oral Health Program (OHP) will promote sealants through screening and referral activities. The OHP will support direct delivery of sealants at the local health department level, and promote education/awareness programs among dental professionals, pediatricians and the public. The OHP will concentrate on training local health departments on screening and referring procedures for children attending high risk elementary schools in their communities.

The OHP will support and provide technical assistance in collaboration with Dental Select's "Sealant For Smiles" school-based preventive dental program. Additional funding that has been made available will allow the "Sealant for Smiles" program to expand to include Tooele, Summit Davis and Salt Lake Counties. It is anticipated that more than 6,000 children will be screened and over 15,000 sealants placed on low-income uninsured and Medicaid/CHIP insured children.

The OHP will also support and provide technical assistance to sealant placement projects for low-income uninsured and Medicaid/CHIP insured children coordinated and conducted by Dental Hygiene Programs at Weber State University, Salt Lake Community College, Utah Valley State College, Utah College of Dental Hygiene and Dixie College. Sealant Projects in the Salt Lake Valley Health Department, Weber-Morgan Health Department, Utah County Health Department and Southwest Utah Health Department will include, in addition to health department and school personnel, volunteer dental hygienists, dentists and dental assistants.

The OHP, in collaboration with other state agencies and organizations such as the Utah Oral Health Coalition, Medicaid (EPSDT), CHIP and Community Health Center Dental Clinics, will promote oral health prevention including sealant utilization to the public. Other activities will include making presentations and providing educational material regarding the benefits of sealants to dental professionals, pediatricians and other health care providers who have opportunities to promote and refer children for sealants.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	4.5	4.4	4.9	4.6	5.1
Annual Indicator	5.0	4.6	5.2	5.2	2.9

Numerator	32	30	35	35	20
Denominator	638700	653225	668784	668784	683326
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	4.5	4.4	4.3	4.2	4.1

Notes - 2007
Numerator: Office of Vital Records and Statistics. UDOH 2006
Denominator: IBIS Population estimates for 2005

Notes - 2006
Numerator: Office of Vital Records and Statistics. UDOH 2005
Denominator: IBIS Population estimates for 2005

Notes - 2005
Numerator: Office of Vital Records and Statistics. UDOH 2005
Denominator: IBIS Population estimates for 2005

a. Last Year's Accomplishments
The performance measure was achieved. The Performance Objective was 5.1 and the Annual Indicator was 2.9. This is the lowest death rate noted in the last thirty years.

The Violence and Injury Prevention Program (VIPP) collaborated with numerous partners to implement interventions for reducing motor vehicle crash deaths to children in Utah. Funding and assistance to each local health district (LHD) was provided so that they could continue to conduct injury prevention programs that included promoting bicycle, pedestrian, and motor vehicle safety. Over 235,000 people were reached statewide through 863 events promoting motor vehicle safety. In addition, there were 112 media events promoting motor vehicle safety.

VIPP worked with LHDs to promote the use of child safety seats. Interventions included: promoting car seat use to over 28,300 children and parents through 285 awareness activities at day cares, schools, doctor offices, and businesses; distributing over 1,700 child safety seats; conducting 59 car seat checkpoints; and educating the public through 33 media activities.

During FY07, pedestrian safety interventions included: promoting pedestrian safety to over 160,750 individuals through 136 events; conducting successful Walk to School Day events at 90 schools and Green Ribbon Month events at 130 schools to increase awareness of pedestrian safety; coordination with other agencies on pedestrian safety issues regarding enforcement and the environment; educating the public through 23 media activities; and, providing pedestrian safety information on the UDOH website. VIPP also coordinated a new "Heads Up Utah" pedestrian safety media campaign with funding from the Utah Department of Transportation.

During FY07, bicycle safety interventions included: conducting161 community activities reaching 16,800 individuals; organizing 17 bike safety media activities; and, distributing 5,400 bike helmets. VIPP conducted the annual Utah bike helmet study and found that the helmet use rate for elementary school-age bicyclists increased slightly from 22% to 23%. The VIPP presented the "Share the Road With Bicycles" program to new driver education instructors and also to 10 driver education classes.
VIPP is the lead agency for Safe Kids Utah. Local chapters conducted motor vehicle safety

events and distribution of child safety seats (funded by various partners). Over 100,000 English and Spanish newsletters, which dealt with a variety of motor vehicle safety topics, were produced and distributed statewide. Safe Kids Utah was active in conducting numerous interventions throughout the state including: maintaining a website; conducting events for checkpoints, Child Passenger Safety Week, and Safe Kids Week; and, working with the media to promote motor vehicle safety.

VIPP also coordinated a statewide campaign with all LHDs in Utah aimed at reducing deaths to teens from motor vehicle crashes. Although this campaign targeted 15-19 year olds it also had a tremendous effect on children, as teens are the drivers in 27% of all motor vehicle crashes and 18% of all fatal crashes. Through this campaign, 173 events were conducted reaching over 17,000 individuals. In addition, there were 23 media events promoting teen motor vehicle safety. A Utah Teen Driving Task Force was also created to coordinate the efforts of several agencies working together on this issue. The task force brought together driver license officials, emergency responders, hospitals, law enforcement, public health, public safety, school officials, state legislators, and transportation officials. The task force started a new campaign entitled "Don't Drive Stupid." Multifaceted interventions included: education; mobilization of community partnerships to identify and solve traffic safety problems; partnerships with law enforcement; conducted community assessments to determine where permanent seatbelt reminders are needed; and, installed permanent seatbelt reminders in targeted communities.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Violence and Injury Prevention Program collaborated with state and local partners to develop and implement strategies for reducing motor vehicle crash deaths among children.				X
2. The Violence and Injury Prevention Program and local health departments reached over 235,000 people in Utah through 863 events promoting motor vehicle safety. In addition, there were 112 media events promoting motor vehicle safety.			X	
3. The Violence and Injury Prevention Program and local health departments promoted car seat use to over 28,300 children and parents through conducting awareness activities at day care centers, schools, churches, doctors' offices, and businesses.			X	
4. The Violence and Injury Prevention Program and local health departments distributed over 1,700 car seats and 5,400 bicycle helmets.			X	
5. 130 schools participated in Green Ribbon Month, a statewide pedestrian safety campaign promoted by public health.			X	
6. The Violence and Injury Prevention Program remained the lead agency for Safe Kids Utah. Safe Kids Utah distributed over 100,000 Safe Kids newsletters and conducted events for Safe Kids checkpoints, Child Passenger Safety Week, and Safe Kids Week.				X
7. Funding and training provided to local health departments for a coordinated statewide campaign to promote teen motor vehicle safety. There were 173 events conducted reaching over 17,000 people and 23 media events.			X	
8.				
9.				
10.				

b. Current Activities
The Violence and Injury Prevention Program (VIPP) will continue collaboration with partners to implement strategies for reducing motor vehicle crash (MVC) deaths among children.

Funding and assistance to each local health district (LHD) will be provided so that they can conduct interventions to promote bicycle, pedestrian, and occupant safety.

Child car seat efforts will include such activities as: partnering with LHDs to promote car seat use; conducting inspections; distributing low cost car seats; promoting new booster seat law; working with the media; and, providing UDOH website information.

The VIPP is the lead agency for Safe Kids Utah and will oversee 14 coalitions and chapters statewide. Reducing MVC injuries is a primary target area. Each chapter will coordinate interventions in their area. Over 100,000 newsletters will be published and distributed with safety tips and resources.

The VIPP will coordinate a bicycle and pedestrian safety campaign by promoting safety events, partnering with other organizations, distributing educational materials, collecting data, working with the media, publicizing bike rodeo trailer, making low cost helmets available, conducting and distributing results from annual bike helmet observation survey, and providing UDOH website information.

The VIPP will also coordinate a statewide campaign with all Utah LHDs aimed at reducing MVC deaths to teens (who have the highest death rates). This campaign will impact teens and younger children.

c. Plan for the Coming Year
The Violence and Injury Prevention Program (VIPP) will continue collaboration with numerous partners to implement strategies for reducing motor vehicle crash deaths among children in Utah.

Funding, training, and technical assistance will be provided to each local health district (LHD) so they can continue to conduct injury prevention interventions. These interventions will include promoting bicycle, pedestrian, and motor vehicle safety.

Child car seat efforts will continue including such activities as: partnering with LHDs to promote the use of car seats; conducting car seat inspections; assisting with training sessions in local communities; distributing low-cost car seats; educating school age children; working with the media; supporting efforts to increase correct car seat use; promoting new booster seat law; and, providing information on the Utah Department of Health (UDOH) website.

The VIPP is the lead agency for Safe Kids Utah and will oversee 14 Safe Kids coalitions and chapters statewide. One of the coalition's primary target areas is reducing motor vehicle crash injuries. Each chapter will build and maintain an active chapter and coordinate interventions in their area. Over 100,000 newsletters, printed in English and Spanish, will be published and distributed to parents with motor vehicle safety tips and resources.

The VIPP will continue coordinating a pedestrian safety campaign by promoting pedestrian safety events (Green Ribbon Month, Safe Routes to School, and Walk to School Day), partnering with Gold Medal Schools and community organizations, distributing educational materials, collecting and analyzing data, working with the media, coordinating with other agencies on issues regarding enforcement and the environment, and providing information on the UDOH website.

The VIPP will coordinate a bicycle safety campaign by working with the media, distributing educational materials, providing information on the UDOH website, collecting and analyzing data,

publicizing availability and scheduling bike rodeo trailer, teaching bike safety at community events, promoting bike safety events, seeking sources for low cost bike helmets, making helmets available for distribution through community partners, conducting annual observation survey on bike helmet use in Utah, and distributing the results of the survey and making recommendations for improving helmet use statewide.

Due to the fact that motor vehicle crash death and hospitalization rates are highest in the 15-19 year age group, the VIPP will coordinate a statewide campaign with all LHDs in Utah aimed at reducing deaths to teens from motor vehicle crashes. Multifaceted interventions will include: Education; mobilizing partnerships to identify and solve traffic safety problems; partnering with law enforcement; and, installing seatbelt reminder signs in communities. Although this campaign is targeted at 15-19 year olds, it is anticipated that it will also have a tremendous effect on younger children.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				53	50
Annual Indicator			52.4	49.9	55.6
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	56	56.5	57	57.5	58

Notes - 2007
The data reported are from the National Immunization Survey published in 2007. These data are only reported by percentage so no numerator or denominator is available for state level reporting.

Notes - 2006
The data reported are from the National Immunization Survey 2006. These data are only reported by percentage so no numerator or denominator is available for state level reporting.

Notes - 2005
The data reported are from the National Immuniztion Survey. These data are only reported by percentage so no numerator or denominator is available for state level reporting.

a. Last Year's Accomplishments
The performance measure was achieved. The Performance Objective was 50% and the Annual Indicator was 55.6%.

The data on this measure, the percentage of mothers breastfeeding their infants at 6 months of age, was collected in a slightly different way from the previous year. The CDC National Immunization Survey data now collects breastfeeding data according to the year of the child's birth, rather than by year of the respondent interview. The Indicator data is on infants born in 2004 from interviews conducted through December of 2006. The survey will continue to be

administered in this way in the future. The breastfeeding data are from two years prior because the main purpose of the survey is to collect immunization data; however, there is likely to be little recall bias, as women usually very clearly remember the age of their infants when they were weaned.

The Women Infants and Children (WIC) Program, the Reproductive Health Program (RHP) and the Utah Breastfeeding Coalition (UBC) continued to collaborate with the goal of increasing Utah's percentage of women who breastfeed their infants at 6 months of age.

The Healthy People 2010 goal is for 50% of mothers to breastfeed their babies at 6 months of age. Eight other states have also met this goal. Because of the many benefits of continued breastfeeding and risks of not breastfeeding, we will continue to strive to increase this percentage every year, as well as other breastfeeding measures such as breastfeeding at 12 months and measures of breastfeeding exclusivity.

Many activities occurred from July, 2006-June, 2007 to promote the continuation of breastfeeding to 6 months of age and longer. A month-long event titled "The Breastfeeding Café" was held in the downtown Salt Lake City library. This outreach activity provided a continuing education event, television and radio exposure, and interactions with library patrons and participants in special events. The WIC program held a peer counseling training and a implemented a new computer system design which included a new model of counseling and breastfeeding data fields. Because many women shorten their breastfeeding experience due to returning to the workforce, a survey project on Workplace Lactation Support Practices and Attitudes of employers was completed and the results disseminated. The major findings from the survey were that organizations would be more likely to offer support services if they had information on successful programs in other organizations and on the benefits to employers such as potential cost savings. A packet for employees and their managers was developed and distributed, and site visits were made to businesses interested in improving their worksite lactation programs. A partnership with the Utah Psychologically Healthy Workplace led to the recognition of two worksites at an awards program. Collaboration with the Bureau of Health Promotion's Worksite Wellness program led to a presence and display at two conferences. The WeeCare pregnancy program (part of the Reproductive Health Program) provided breastfeeding support to 1200 enrollees through discussion of breastfeeding intentions and plans to maintain lactation if returning to work or school, with additional resources of support identified. Individualized materials were sent to participants, and a breastfeeding "warm-line" (hours 8 AM-5PM) was staffed. The Reproductive Health Program placed breastfeeding information on its website.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Breastfeeding Café event August 1-30, 2006, downtown Salt Lake City Library				X
2. WIC Peer Counseling training				X
3. Updated WIC breastfeeding data collection				X
4. Workplace Lactation Support survey and resultant Workplace Lactation packet				X
5. Partnership with Utah Psychologically Healthy Workplace and Workplace Wellness organization				X
6. WeeCare pregnancy program lactation support and patient education		X		
7.				
8.				
9.				

10.				

b. Current Activities
The Women Infants and Children (WIC) Program, the Reproductive Health Program (RHP) and the Utah Breastfeeding Coalition (UBC) are continuing to collaborate with the goal of increasing the initiation and duration of breastfeeding.

The WIC program sponsored a community breastfeeding workshop and Grand Rounds for Family Practice residents, and will also be partnering with the UBC to sponsor training entitled "the Business Case for Breastfeeding" which provides a toolkit for working with local businesses on worksite lactation programs.

The RHP is promoting breastfeeding with information on its website, distribution of information at health fairs, and partnering with the UBC. RHP supported the development and purchase of bookmarks highlighting the risks of not breastfeeding and directing people to the Coalition website for more information. These bookmarks were given to childbirth educators to disseminate among students, and to attendees at the community breastfeeding workshop. The WeeCare pregnancy program is encouraging participants to access postpartum breastfeeding counseling should they run into questions or concerns. Materials are accessed on successfully breastfeeding past early challenges, returning to work or school, and the benefits of the continuation of breastfeeding. The PRAMS (Pregnancy Risk Assessment Monitoring System) is continuing to ask four survey questions on breastfeeding, which identify target populations.

c. Plan for the Coming Year
The Women Infants and Children (WIC) Program, the Reproductive Health Program and the Utah Breastfeeding Coalition will continue to look for new opportunities to promote the rates of breastfeeding to the age of six months and longer. Since pediatricians are the most likely medical professionals to encounter a breastfeeding dyad and play a very significant role in the success of breastfeeding, we will seek involvement with the Intermountain Pediatric Society and with the Utah Pediatric Partnerships to Improve Health Care Quality. The attention given to the obesity epidemic is also an opportunity to collaborate with other areas of health promotion, since breastfeeding has a strong correlation with childhood obesity and maternal weight retention. Addition organizations and agencies to seek collaboration with include the Utah Chapter of the March of Dimes through their new Healthy Business Healthy Babies materials.

We will continue to monitor breastfeeding rates and related statistics. The PRAMS program will begin to ask in the 2009 survey why a woman stopped breastfeeding in addition to the other breastfeeding questions in order to better target interventions.

The WIC program is planning to offer community and WIC staff training opportunities such as a 40 hour lactation course, a Building Bridges community workshop, increasing educational materials for staff training at clinic sites, and a state annual conference. WIC also will increase collaboration with the breastfeeding community and with other organizations and agencies, and sustain an active Peer Counseling Program, including a Hispanic Breastfeeding Exclusivity Campaign with McKay Dee Hospital, the University of Utah and the Multicultural Health Committee.

The Utah Breastfeeding Coalition is planning the third annual Breastfeeding Café event. Bi-monthly teleconference calls will continue, where state coalitions are presented information and then have a chance to interact and discuss issues. The Coalition plans to continue to offer continuing education events, a community workshop, and to more fully develop the Breastfeeding Case for Workplace Lactation Support.

The WeeCare Program will continue to promote continued breastfeeding amongst its clientele, and to obtain qualitative data about women's reasons for not initiating breastfeeding or for early weaning. With these insights, the program will implement strategies in an effort to help all women be well informed and to make informed choices affecting their breastfeeding experiences.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	96.5	96.5	97.5	97.5	97.9
Annual Indicator	97.4	97.1	97.9	98.0	98.0
Numerator	49740	50336	51478	53454	53454
Denominator	51069	51835	52563	54532	54532
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	97.5	98	98	98	98

Notes - 2007
Numerator Source: Data were obtained from the Hearing, Speech, and Vision Services Program, UDOH
Denominator Source: Data are based on 2006 occurrent births obtained from Office of Vital Records and Statistics, UDOH.

Notes - 2006
Numerator Source: Data were obtained from the Hearing, Speech, and Vision Services Program, UDOH

Denominator Source: Data are based on 2006 occurrent births obtained from Office of Vital Records and Statistics, UDOH.

Notes - 2005
Numerator Source: Data were obtained from the Hearing, Speech, and Vision Services Program. UDOH.
Denominator Source: Data are based on 2005 occurrent births obtained from Office of Vital Records and Statistics. UDOH.

a. Last Year's Accomplishments
Performance measure was achieved. Performance Objective was 97.5%; Annual Indicator was 98%.

Utah had 54,532 births in 2006. Ninety-eight percent (98.0%) of occurrent births were screened for hearing loss with a 94.9% pass rate as inpatient, and a 98.6% pass rate when outpatient results are included. Home birth screening rates increased from 16.5% of 2005 births to 17.1% of 2006 births. Three hundred eighty-four (384) newborns (0.7%) were referred for diagnostic evaluation, and sixty births were identified with permanent congenital hearing loss, with many still

in diagnostic process.

Utah participated in a five state Loss-to-Follow-up Study funded by CDC, HRSA. Results from the June 2007 report will be used for program improvement statewide. Results were presented to Newborn Hearing Screening Committee (NBHSC) in Aug 2007 and at the Sept. EHDI Workshop.

A Utah EHDI workshop was held Sept 2006. The Colorado EHDI Director gave an overview of their State program and insight on rural follow-up and loss to follow-up issues. Presentations included: screening to diagnosis to implantation, educating primary care providers, family support, and new screening equipment. Five Utah regional trainings were held March 2007 for urban, rural and frontier issues. Agenda included: screening practices, family interaction, data quality, program management, and two-stage screening. Updated materials were distributed.

The 2007 National EHDI Conference convened in Salt Lake, March 2007. Seventeen scholarships were provided to audiologists/NBHSC members. Registrants attended presentations on topics relevant to their program/practice.

Monthly distribution of Hi*Track reports to hospitals enabled more timely data corrections and earlier tracking. A Guide to Pediatric Audiologists in Utah resource brochure was updated.

Phase II of the Parent Infant Program (PIP) project to increase the number of children referred to Early Intervention (EI) was implemented. Three new programs have an Advisor contact the family when a child fails the hearing screening. Participation in Partnering for Success of Children with Hearing Loss and Investing in Family Support conferences brought together state EHDI directors, Part C coordinators and a plan was created to build a comprehensive system of family/parent support. EI and EHDI updated hearing screening standards. Collaboration with Vital Records updated the birth certificate worksheet to identify/collect hearing risk indicators.

EHDI and PIP established data sharing agreements. PIP reports monthly on referrals/ enrollments for children referred for deaf or hard-of-hearing services. EHDI protocol added a letter telling parents their child was referred to PIP and PIP would be calling to discuss enrollment options.

A hearing screening flip chart presentation for care providers was developed, focused on linking babies to Medical Home and EI. The EHDI Director, CSHCN Director, Director of The National Center for Hearing Assessment and Management (NCHAM) and EHDI Chapter Champion participated in the Biologic Basis of Pediatric Practice Symposium held Sept 2006, focused on congenital hearing loss. Educational objectives for pediatricians were to increase awareness on congenital hearing loss and current research activities.

Utah EHDI participated with HRSA, NCHAM, EPSDT directors at a workshop to maximize service, funding, follow-up for children covered by Medicaid. Targeted case management hearing screening questions were developed for home health nurses to identify infants who miss or fail hearing screening.

Beta testing of Web-enabled Hi*Track 4 data system began June 2007, running as a parallel system to Hi*Track 3.5. Software enhancements will be made according to user feedback. Improved EHDI reporting and data sharing/integration goals were included in updates to Hi*Track.

In March 2007 a study using Birth Certificate Application and CHARM data sharing system to alert parents of children who need follow-up was initiated. When a parent applies for a certificate, an automatic lookup is prompted in CHARM that searches the EHDI data. If the baby requires additional screening, follow-up, the system generates an alert letter given to the family with the birth certificate. The goal is to improve timeliness of EHDI services; reduce the number of infants

lost to follow up.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided workshops and tutorials addressing national and state issues (including urban, rural and frontier needs) through the annual Utah EHDI conference and regional meetings.				X
2. Continued to address uniform standards in screening, diagnostic testing, training, and experience.				X
3. Developed a customizable newborn hearing screening flip chart presentation for primary care providers.				X
4. Established partnerships with EHDI, CSHCN and EPSDT.				X
5. Developed targeted case management protocol for use with home health nurses that identify infants who missed or failed initial newborn hearing screening.				X
6. Initiated Web-based Hi*Track data system beta testing				X
7. Improved EHDI reporting and added CHARM data sharing/integration goals to Hi*Track updates.				X
8. Initiated the Birth Certificate Alert Project to alert parents of children who need follow-up on failed hearing screening results.			X	
9.				
10.				

b. Current Activities

On-going activities for FY08: 1) Develop a lay midwife training system for newborn hearing screening issues. A survey will evaluate educational and technical needs, and a screening project will be initiated. 2) Use hospital self-assessment survey results to target needs for site visits and training to hospital programs. Develop training materials for least effective programs. Identify urban, rural and frontier issues. 3) Develop a more timely tracking system for babies in diagnostic process. Generate a review protocol/timeline for audiology sites to monitor diagnostic/referral process of infants needing diagnostics. 4) Develop a technical training workshop on pediatric audiology evaluation that assures audiologists have current knowledge of "best practice" protocols. 5) Develop a system to ensure all stakeholders are aware when a child is diagnosed with a hearing loss. Confidentiality issues will be researched and a reporting system between EI/PIP and EHDI will be finalized. 6) Increase family to family support systems. Research national support organizations, encourage/support local chapters. 7) Research/develop an alert system to help audiologists track "high-risk" infants. 8) Develop a plan to address risk factors collected, and integrate risk factors from birth certificate work sheet via CHARM into EHDI follow-up activities. 9) Design a needs assessment for pediatricians to determine educational needs. Collaborate on an EHDI module for the Utah Medical Home website.

c. Plan for the Coming Year

During FY09, the following activities are planned to support national newborn hearing screening and follow-up goals: Existing protocols for state and hospital screening programs will be evaluated and updated. Focus will be on standardizing educational information, improving counseling approaches to families, scheduling follow-up activities, and reporting follow-up results. Annual progress will be reviewed, barriers and emerging issues identified, and a plan will be developed to address programs needs. Compliance of 2007 Joint Committee on Infant Hearing (JCIH) recommendations will be addressed. A statewide education and training conference will be held for all hearing screening programs.

Hospital compliance of current CDC data reporting guidelines will be improved. (HRSA supports the CDC reporting guidelines and is a partner on national EHDI reporting committees.) Regional trends will be explored and at-risk and progressive/late-onset issues will be reviewed. Upgraded HI*TRACK data tracking software beta testing will be completed and be made available to hospitals. Additional sites will be added to birth certificate alert/ loss to follow-up project. Audiology referral documentation will be increased.

Efforts to decrease the number of infants older than three months of age who do not have a definitive hearing diagnosis will be implemented in collaboration with the State EHDI staff, Utah's Newborn Hearing Advisory Committee, Utah School for the Deaf, and NCHAM. Birthing facility referral protocols will be reviewed for appropriateness and content. A parent survey on the age of identification of hearing loss and the age of hearing aid fitting will be developed, conducted and tabulated.

Activities to decrease the number of infants "missed" for newborn hearing screening will be increased. Education projects for Medical Home providers will be evaluated and updated to assure providers encourage and support hearing screening. The lay midwife pilot project will be expanded as additional screening equipment is procured to help provide earlier and increased testing for home births. We will review the potential of developing a network if audiologists/screeners willing to provide free screening for families without financial resources.

Linking children identified with hearing loss to appropriate intervention services, including counseling and a connection to a medical home will be increased through a variety of activities. A fax-back referral process with audiologists and primary care providers will be developed. Family-to-family support, advocacy, and collaboration with appropriate community resources will be improved. An EHDI in-service presentation for professionals will be developed for Utah's AAP EHDI Chapter Champion.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	6.5	7.3	8.1	8.6	10.3
Annual Indicator	7.3	8.2	8.5	10.3	9.1
Numerator	54500	62850	67000	83200	76700
Denominator	742867	771112	788452	804569	838407
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	9.1	9.1	8.9	8.9	8.9

Notes - 2007
Numerator: The proportion of children with no insurance calculated using the data from the Utah Health Status Survey 2007.
Denominator: IBIS Population estimates

Notes - 2006

Numerator: The proportion of children with no insurance calculated using the data from the Utah Health Status Survey 2006.
Denominator: IBIS Population estimates

Notes - 2005
Numerator: The proportion of children with no insurance calculated using the data from the Utah Health Status Survey 2005.
Denominator: IBIS Population estimates

a. Last Year's Accomplishments
The performance measure was achieved. The Performance Objective was 10.3 and the Annual Indicator was 9.1.

In 2007 the percent of children in Utah who lack health insurance was 9.1% as compared to a national figure of 11.7% (U.S. Census Bureau, 2006). This lower percentage was due in part to Utah's large family size (largest in the nation) and relatively low family income, which results in more children being eligible for the Children's Health Insurance Program (CHIP). However, although the uninsured rate was marginally lower than the national average, approximately 76,700 children in Utah lack insurance.

Of those uninsured children, national figures indicate that seven out of ten are eligible for either Medicaid or CHIP. This figure means that the most effective way to reduce the percentage of children without health insurance is to find ways to increase enrollment in those programs.

The Division of Community and Family Health Services staff continued efforts on collaborating with the CHIP and Medicaid agencies as well as Voices for Utah Children, local health departments, schools, Head Start agencies, pediatric health care providers and dentists. This outreach effort was to encourage families to enroll their children in CHIP or Medicaid. Because of the open enrollment this year for CHIP, these efforts may have a larger impact as compared to earlier years. Specifically, the Division staff participated in the CHIP advisory meetings, Voices for Utah Children's projects, Head Start collaboration efforts, Early Childhood Council meetings, Utah Pediatric Partnership to Improve Healthcare Quality Learning Collaboratives and the Utah Oral Health Coalition.

In addition, the Utah Department of Health implemented a mass media campaign, including television, radio, print, and internet advertising to spread the word to the public that children no longer have to wait for an open enrollment period to enroll in CHIP and to encourage families to apply for benefits.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborated with Medicaid and CHIP.				X
2. Collaborated with other agencies such as LHD's, Head Start, etc.				X
3. Participated in meetings with collaborative agencies.				X
4. Continue mass media campaign that is specifically targeted toward CHIP and open enrollment.			X	
5.				
6.				
7.				
8.				
9.				

10.				

b. Current Activities
The 2007 Legislature allocated an additional $4 million to open CHIP enrollment to eligible children and also provided additional Medicaid funding for the anticipated increase in children who are eligible for Medicaid. Eligibility workers are now all employees of the Department of Workforce Services. The Division has tracked numbers of children enrolled in the Medicaid and CHIP to monitor capacity of the increases to handle the numbers of eligible children applying for services. The 2008 Legislature allocated enough funding for the state CHIP program to maintain continuous open enrollment. This too will help reduce the number of children without health coverage.

Current activities, such as media campaigns continued to promote availability of the program to increase enrollment. The Department worked closely with the Governor to develop additional strategies to enroll more eligible children into Medicaid and CHIP.

c. Plan for the Coming Year
In 2007-08 the percent of children in Utah who lack health insurance is 10.9% as compared to a national figure of 11.7% (U.S. Census Bureau, 2006). As mentioned in the Annual Report, this lower percentage is due in part to Utah's large family size (largest in the nation) and relatively low family income, which results in more children being eligible for the Children's Health Insurance Program (CHIP). However, although the uninsured rate is marginally lower than the national average, approximately 76,700 children in Utah lack insurance.

One of the identified and important ways to reduce the percentage of children without health insurance is to find ways to increase enrollment within Medicaid and CHIP. Utah's children who didn't have health insurance have increased from 6.8% (YR 2001) to 10.9% (YR 2007).

The Division of Community and Family Health Services staff will continue to focus efforts on collaborating with CHIP and Medicaid agencies to increase open enrollment for CHIP. This open enrollment has changed because of the additional monies the Utah State Legislature allocated to this program. With dwindling state budgets, it is important for the Department to continue advocating for higher enrollment in CHIP. The Divisions role will be to work closely with the CHIP advisory and help demonstrate the effectiveness of CHIP to the State Legislature for continued funding and future funding. Identification of data that can be presented to the State Legislature will assist the CHIP program.

Continue the collaboration with Voices for Utah Children, local health departments, schools, Head Start agencies, pediatric health care providers and dentists to implement outreach efforts to encourage families to enroll. Because of the open enrollment this year for CHIP, these efforts may have a larger impact as compared to earlier years. The Division will increase web capacity to provide additional resources for local schools to help children get enrolled in CHIP.

In addition, the Utah Department of Health will continue its mass media campaign, including television, radio, print, and internet advertising to spread the word to the public that children no longer have to wait for an open enrollment period to enroll in CHIP and to encourage families to apply for benefits.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				21.6	21.6
Annual Indicator			21.6	21.8	21.8
Numerator			6541	6558	6558
Denominator			30282	30083	30083
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	21.6	21.6	21.6	21.5	21.5

Notes - 2007
The data are from the 2005 Pediatric Nutrition Surveillance. Table 8C combining the 85th-<95th and greater than or equal to 95th BMI categories.

Notes - 2006
The data are from the 2005 Pediatric Nutrition Surveillance. Table 8C combining the 85th-<95th and greater than or equal to 95th BMI categories.

Notes - 2005
The data are from the 2004 Pediatric Nutrition Surveillance. Table 8C combining the 85th-<95th and greater than or equal to 95th BMI categories.

a. Last Year's Accomplishments
It was not possible to obtain 2006 Pediatric Nutrition Surveillance data due to the deployment of a WIC computer system that failed. Based on 2005 Pediatric Nutrition Surveillance data, the performance measure was not achieved. The Performance Objective was 21.6% and the Annual Indicator was 21.8%.

In FY 2007, the Utah WIC Program collaborated with Utah State University (USU) to write a grant for implementing a culturally sensitive obesity prevention curriculum. However, this grant was not funded. Though it had been planned to modify the Utah WIC food packages to include such healthful items as fresh or canned fruits and vegetables, whole grain breads, brown rice, milk alternatives such as soy products, yogurt and tofu, and different types of canned fish including salmon and tuna, this was not accomplished due to a later than expected release of the USDA Interim Food Rule (12/6/07). The USDA Best Start Loving Support Peer Counselor Program was expanded in all Utah WIC districts for the purpose of supporting increased duration breastfeeding rates, which have been associated with reduced incidence of childhood obesity. There were 31 Peer Counselors hired for 46 WIC clinics which represent an increase in the number hired from the previous year by 8 Peer Counselors. Community partnering was expanded to include in-services for hospitals and Head Start Programs and collaborating with the Utah Breastfeeding Coalition. Finally, key individually tailored health messages were incorporated into all Utah WIC certification visits as the local WIC health professionals facilitated goal setting with all WIC participants.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Collaborated with USU on a culturally sensitive obesity prevention curriculum				X
2. Reviewed and approved local WIC district Peer Counselor plans				X
3. Observed healthy lifestyle goal setting documented in the WIC computer system during management evaluation visits				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Utah WIC Program will continue to refer all WIC at risk of overweight and overweight children to healthy weight classes offered by Food Stamp Nutrition Education Program (FSNE) and Expanded Food and Nutrition Education Program (EFNEP). A plan to determine the number of WIC participants referred and attending these classes will be developed. The National Maternal Nutrition Intensive Course will be provided for all local WIC health professionals to address nutrition and weight issues from a multiethnic/multiracial perspective. The WIC Program continues to weigh all pregnant women at every visit and to counsel on maintaining healthy weight before, during, and after pregnancy to reduce their risk for obesity as well as their child's risk for obesity. A collaboration between the Utah WIC Program and the Utah Reproductive Health Program entitled, "The Healthy Weight in Women Action Learning Collaborative" will continue to promote healthy weight gain during pregnancy and healthy outcomes.

A plan and timeline for implementing the new USDA Food rule will be developed to ensure that healthier food choices become a part of WIC Food Packages in 2009. A Participant Satisfaction Survey will be administered in all WIC clinics to determine participant preferences for the new healthier food options. A community needs assessment tool designed to determine access to healthy foods and physical activity resources will be piloted in the Ogden WIC clinic.

c. Plan for the Coming Year

For the children, the Utah WIC Program will continue to collaborate with the Utah State University Expanded Food and Nutrition Education Program (EFNEP) and the Food Stamp Nutrition Education Program (FSNE) by referring all WIC children at risk of overweight and overweight to these programs' special healthy weight classes.
A plan will be developed with the Utah WIC Program IT Manager to generate computer reports that will indicate the number of WIC children referred to these two programs (FSNE and EFNEP). A strategy will be planned to periodically determine and document the number of WIC participants who complete these special healthy weight classes taught by FSNE and EFNEP.

The results of the 2008 Participant Satisfaction Survey and the information gathering process will be used to develop WIC food packages and a new WIC Approved Food List with healthier food items, while reducing the total fat, saturated fat, cholesterol and refined sugar content. The Utah WIC Program plans to analyze results of a community needs assessment survey designed to determine access to healthy foods and physical activity resources piloted in the Ogden WIC clinic and consider for administration in all Utah WIC clinics.

A one day training entitled VENA (Value Enhanced Nutrition Assessment) will be provided for all WIC Health Professionals at the Utah State WIC Conference in September 2009. This training

will consist of in-depth, interactive sessions on critical thinking and rapport building to provide advanced level nutrition interview skills to facilitate a more comprehensive, positive health outcome based assessment and intervention strategy.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				4.6	4.2
Annual Indicator			4.7	4.3	4.3
Numerator			2386	2228	2326
Denominator			50653	51517	53475
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	4.2	4.1	4	3.9	3.8

Notes - 2007
Utah Vital Records birth data, 2006.

Notes - 2006
Office of Vital Records and Statistics. UDOH 2005

Notes - 2005
Office of Vital Records and Statistics. UDOH 2004

a. Last Year's Accomplishments
The performance measure was not achieved. The Performance Objective was to reduce the number of pregnant women smoking in the third trimester of pregnancy to 4.2% and the Annual Indicator was 4.3% (Utah Vital Records 2006 data).

The Reproductive Health Program (RHP) monitored statistics on third trimester smoking through vital records and PRAMS data. While the performance measure was not met, 2006 PRAMS data indicate that the number of cigarettes smoked during the third trimester is a decrease from the number smoked in the two previous trimesters. While not the optimal result, the decrease in cigarettes smoked does decrease fetal exposure to the by-products of nicotine and other toxins.

According to 2006 PRAMS data, among women smoking in the third trimester of pregnancy only 2.3% indicated that their prenatal care was funded by private insurance while prenatal care for 16.2% of third trimester smokers was funded by Medicaid. This supports the RHP's focus on targeting cessation activities toward Medicaid enrollees. An indicator profile for smoking in the third trimester of pregnancy is being developed and will be available on Utah's Indicator-Based Information System for Public Health (IBIS-PH) by September of 2007. A three minute presentation on smoking cessation during pregnancy was aired in June of 2006 during a Baby Your Baby segment on KUTV, the local CBS affiliate and, therefore, not repeated during FY07. The collaborative project with the Tobacco Prevention and Control Program to distribute information packets regarding smoking cessation resources for Medicaid providers was shelved

in favor of targeting the perinatal case managers of Medicaid contracted health plans. This method of implementation will be less expensive and will place information on smoking cessation resources in the hands of case managers with more one on one contact time with clients than physicians. This alternative project has been difficult to implement due changes in Medicaid personnel and difficulties in scheduling. It is now scheduled for Spring of FY08.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitoring of vital records and PRAMS data of women reporting smoking in the third trimester of pregnancy				X
2. Development of an IBIS-PH indicator related to smoking in the third trimester to be publish to the website by September 2007				X
3. Airing of a 3-minute spot on the local CBS affiliate regarding smoking cessation in pregnancy			X	
4. Working toward collaboration with Medicaid to present an in-service to perinatal case managers of Medicaid contracted health plans on the hazards of smoking in pregnancy and cessation resources available for Medicaid clients				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Reproductive Health Program (RHP) is monitoring vital records and PRAMS data to track the trend in smoking in the third trimester of pregnancy and the demographics of women in that category. In September of 2007, an indicator report on smoking in the third trimester of pregnancy was published on the Utah Indicator-Based Information System for Public Health (IBIS-PH). An in-service for perinatal case managers affiliated with Medicaid contracted health plans is being developed for presentation in the spring of 2008. Additionally, a project to disseminate information on available smoking cessation resources for pregnant teens attending alternative schools in Utah is in development in collaboration with the Utah Department of Health's Tobacco Prevention and Control Program.

c. Plan for the Coming Year

During FY09, the Reproductive Health Program (RHP) will continue to collaborate with the Utah Department of Health's Tobacco Prevention and Control Program (TPCP) to increase women's health care providers' and the public's awareness of available smoking cessation resources for pregnant women. The RHP will also collaborate with the University of Utah's Teen Mother and Child Program to improve smoking cessation rates among enrolled pregnant and parenting clients. The RHP will monitor outcomes of its efforts to collaborate with alternative schools to promote awareness and use of smoking cessation resources for pregnant teens enrolled in their schools.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	12	11.9	14.2	13.9	13.2
Annual Indicator	14.4	14.0	9.3	11.3	11.3
Numerator	28	27	18	22	22
Denominator	194145	193218	194147	195330	195330
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	13.2	13.2	13	13	13

Notes - 2007
Numerator: Office of Vital Records and Statistics death data. UDOH 2006
Denominator: IBIS Population estimates for 2006 based on GOPB population estimated 2005 baseline.

Notes - 2006
Numerator: Office of Vital Records and Statistics death data. UDOH 2006
Denominator: IBIS Population estimates for 2006 based on GOPB population estimated 2005 baseline.

Notes - 2005
Numerator: Office of Vital Records and Statistics. UDOH 2004
Denominator: IBIS Population estimates for 2004

a. Last Year's Accomplishments
The performance measure was achieved. The Performance Objective was 13.2 and the Annual Indicator was 11.3.

The Children's Mental Health Promotion Specialist assisted in the review and selection of applications for the lead agency (Department of Human Services Division of Substance Abuse and Mental Health -- DSAMH) in writing a state plan for suicide prevention among all ages. UDOH is represented on the council and is assisting in the completion of the plan. Responsibility for the Youth Suicide Taskforce (YSTF) as previously led by the Department of Health has been transferred to DSAMH to address along with suicide prevention among all ages.

A report was completed on youth suicide (15-19 years old) for a state legislator for use in determining language for a proposed suicide prevention act. Office of Public Health Assessment staff and Department of Human Services staff contributed to the report which was presented to the legislator prior to the beginning of the 2007 Legislature.

A statewide professional mental health training needs assessment survey was completed and initial data analysis was conducted. The findings of the assessment will be compiled into a report which will provide direction for development of appropriate training to enhance the service delivery system for children, including youth at risk for suicide.

The Child, Adolescent and School Health Program provide coordination of outreach efforts to promote suicide prevention with partners including the Suicide Prevention Council which includes: Intermountain Injury Control Research Center, the Violence and Injury Prevention Program (VIPP), NAMI Utah, the Utah Attorney General and the Utah County HOPE Task Force.

VIPP and the Child, Adolescent and School Health programs collaborate in obtaining data related to youth suicide. VIPP completed updates to the State Strategic Plan for Injury and Violence Prevention

The Specialist has worked to increase public awareness about youth suicide risks and prevention efforts by providing training to UDOH staff and consultation with community agencies. The Specialist has provided information to the media on suicide articles to ensure that the information presented was complete and most current. VIPP will continue to provide information on the UDOH Internet site.

Consultation in the review of youth suicide deaths is provided to the Child Fatality Review Committee in order to enhance the quality and quantity of data available on suicide so that the data can be used for prevention purposes. Data collection is used to track trends in rates, to identify new problems, to provide evidence to support activities and initiatives, to identify risk and protective factors, to target high-risk populations for interventions, and to assess the impact of prevention efforts.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Assisted with the selection of a lead agency to prepare a suicide prevention plan				X
2. Collaborated with local agencies and organizations on youth suicide prevention				X
3. Provide consultation to UDOH staff and community agencies on suicide prevention efforts				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Children's Mental Health Promotion Specialist provides leadership relating to suicide prevention efforts for the Utah Department of Health. She participates on youth suicide prevention committees, provides consultation, training, information on suicide trends, and plans activities that relate to suicide prevention from the public health perspective.

The mental health specialist collaborates with the Violence and Injury Prevention Program (VIPP) in obtaining data related to youth suicide and will assist VIPP in completing updates to the State Strategic Plan for Injury and Violence Prevention.

The UDOH mental health specialist will work to increase public awareness about youth suicide risks and prevention efforts through training, media interviews, participation in conference planning and consultation work with other state or community agencies. The Child Adolescent and School Health Program website will be updated to include information on suicide prevention.

The Child, Adolescent and School Health Program participates on the Child Fatality Review Committee by offering consultation in the review of youth suicide deaths to enhance the data on

suicide to be used for prevention purposes. Data analysis will focus on tracking trends in rates, identifying new problems, providing evidence to support activities and initiatives, identifying risk and protective factors, targeting high-risk populations for interventions, and assessing the impact of prevention efforts.

c. Plan for the Coming Year

The Children's Mental Health Promotion Specialist will participate in the Suicide Prevention Council as they move forward on the goals and activities outlined in the Utah State Suicide Prevention Plan. Utah Department of Health will support outreach efforts through the Utah Suicide Prevention Council to promote suicide prevention with government and community partners.

Suicide prevention trainings through the MCHB State Agency Partnerships for Promoting Child and Adolescent Mental Health grant will be offered as indicated by the outcomes of the UDOH Professional Mental Health Provider Training Needs Assessment conducted in 2007. The findings of the assessment have provided direction in the development of appropriate training to enhance the service delivery system for children, including youth at risk for suicide.

The Children's Mental Health Specialist will collaborate with VIPP in obtaining data related to youth suicide and will assist VIPP in completing updates to the State Strategic Plan for Injury and Violence Prevention. VIPP will continue to provide information on the UDOH Internet site.

Public awareness about youth suicide risks and prevention efforts will be addressed through participation in the Suicide Prevention Council, through information to the media and presentation to public and private organizations.

The Specialist will participate on the Child Fatality Review Committee and provide consultation in the review of youth suicide deaths in order to enhance the quality and quantity of data available on suicide so that the data can be used for prevention purposes. Data collection will be used to track trends in rates, to identify new problems, to provide evidence to support activities and initiatives, to identify risk and protective factors, to target high-risk populations for interventions, and to assess the impact of prevention efforts.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	70	71	64	83	80
Annual Indicator	63.2	81.1	79.4	84.4	84.4
Numerator	388	420	424	475	475
Denominator	614	518	534	563	563
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

	2008	2009	2010	2011	2012
Annual Performance Objective	84	84.5	85	85.5	86

Notes - 2007
Office of Vital Records and Statistics. UDOH 2006
The number of hospitals classified as level III increased by one over the reporting period.

Notes - 2006
Office of Vital Records and Statistics. UDOH 2006
The number of hospitals classified as level III increased by one over the reporting period.

Notes - 2005
Office of Vital Records and Statistics. UDOH 2005
The number of hospitals classified as level III increased by one over the reporting period.

a. Last Year's Accomplishments
The Performance Measure was achieved. The Performance Objective was 80% and the Annual Indicator was 84.4%.

The rates of prematurity are increasing in Utah as in the U.S. as a whole. The preterm birth rate in Utah in 2006 was 9.9% of all live births, representing 5,309 infants. A small proportion of premature infants are born weighing less than 1500 grams and are considered very low birth weight (VLBW); in Utah 1.05% of infants born in 2006 were VLBW representing 563 infants. These are the most vulnerable among premature infants and their survival and long term functioning depends on expert perinatal and neonatal care received at health facilities appropriately equipped to deliver high risk infants. Most studies that link neonatal outcomes with levels of perinatal care indicate that morbidity and mortality for VLBW infants are improved when delivery occurs at the appropriate level facility, even after adjustments for severity of illness.

The American Academy of Pediatrics (AAP) Committee on Fetus and Newborn published Guideline on Levels of Neonatal Care in 2004. Partnerships have been established to work with facilities that are delivering VLBW infants but are not meeting the AAP Guidelines for Levels of Care for Neonates.

The Reproductive Health Program has publicized the Guidelines via a statewide report entitled, "Very Low Birth Weight Infants: Are they being delivered at facilities appropriate for their care" to assist these facilities/providers in making appropriate care decisions to promote the best possible outcomes for VLBW infants.

In addition, an internet site maintained by the State contains the Utah Code amendment of rule 432-100-17 which addresses Perinatal Services. A link to this site has been posted on the RHP website, along with the AAP Guidelines for Levels of Care for Neonates for easy access by perinatal healthcare professionals.

Lastly, collaboration with the Utah Division of Health Care Financing (Medicaid) has been established and a newsletter article has been disseminated to Medicaid providers about the importance very low birth weight infants being delivered at facilities for high-risk deliveries and neonates.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Establishment of partnerships with facilities that are delivering VLBW infants but are not meeting the AAP Guidelines for Levels				X

of Care for Neonates				
2. Publication and dissemination of a statewide report entitled, “Very Low Birth Weight Infants: Are they being delivered at facilities appropriate for their care”?				X
3. Link to Utah Code rule 432-100-17 which addresses Perinatal Services from Reproductive Health program website targeting health care providers				X
4. Newsletter article in existing Medicaid provider newsletter on subject				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Although the percentage of VLBW infants delivered at facilities for high-risk deliveries and neonates in Utah has seen improvement, we've not reached the Health People 2010 Objective of 90%. Opportunities that may further increase this trend are critical as research that links neonatal outcomes with levels of perinatal care indicate that morbidity and mortality for very low birth weight (VLBW) infants are improved when delivery occurs in a subspecialty facility rather than a basic or specialty facility even after adjustments for severity of illness.

Analysis of data on VLBW infants that were delivered in facilities that do not meet the new American Academy of Pediatrics (AAP) published guidelines has begun and the review will continue to identify hospitals where this issue is occurring. Partnerships will be established to work with these facilities to assure that they are making appropriate care decisions to promote the best possible outcomes.

The Reproductive Health Program will also follow the Centers for Medicare & Medicaid Services partnership with the National Initiative for Children's Healthcare Quality (NICHQ) initiative to work to improve neonatal outcomes through broader adoption of proven clinical interventions. A colleague, Chris Karlson, who serves on the Department's Perinatal Mortality Review Committee, is serving on this national NICHQ committee. We will collaborate with Dr. Karlson to implement the NICHQ recommended strategies to address this important issue.

c. Plan for the Coming Year

The Healthy People 2010 objective is for 90% of VLBW infants to be delivered at facilities appropriate for high-risk deliveries (Level 3). There is room for improvement throughout Utah as our most recent data indicate that only approximately 84% of VLBW infants were born in Level III facilities that are most appropriate for their care.

To move toward the Healthy People 2010 objective the Department of Health's Reproductive Health Program will monitor birth certificate data to identify VLBW infants who were not delivered in facilities appropriate for optimal care based on the American Academy of Pediatrics (AAP) Definitions of Facilities Based on Capabilities of Neonatal Care. The Program will analyze these data to identify common characteristics associated with these deliveries in order to target interventions. The Program will also develop and implement a survey of hospitals where delivery of VLBW infants occurred to ascertain whether they meet the AAP guidelines for Level 3 care. Lastly the Program will disseminate the "Danger Signs of Pregnancy" triage tool to large prenatal care practices throughout the state to encourage nursing staff to triage women who present with preterm labor appropriately.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	78.2	78.4	78.6	78.2	79
Annual Indicator	78.0	78.0	78.8	79.0	79.0
Numerator	38886	39524	40587	42237	42237
Denominator	49834	50653	51517	53475	53475
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	78.6	78.8	79	79.2	79.4

Notes - 2007
Office of Vital Records and Statistics. UDOH 2006

Notes - 2006
Office of Vital Records and Statistics. UDOH 2006

Notes - 2005
Office of Vital Records and Statistics. UDOH 2005

a. Last Year's Accomplishments
The performance measure was achieved. The Performance Objective was 78.2% and the Annual Indicator was 79.0%.

In FY2007, the Division attempted to collaborate with the Child Adolescent and School Health Program staff on its prenatal to five home visiting program to promote dissemination of information to participating families regarding the importance of early prenatal care, however with staff changes we have not been able to track progress in this area. Local health department nurses provided home visiting services for families with pregnant women and those with young children. The purpose of these visits is to identify health needs and to refer families to appropriate services, such as early prenatal care. Often this is done when LHDs process a Presumptive eligibility application or when they provide care coordination for pregnant women.

Baby Your Baby ads focusing on obtaining financial assistance for pregnant women were aired on television and radio. New ads promoting early and continuous entry into prenatal care were also aired. Print ads in college newspapers continued to be run.

The Division continued its contract with Salt Lake Community Health Centers, Inc. to provide funds for prenatal care services for women without third party payers, many of whom are women of undocumented citizenship status.

The Baby Your Baby program continued to accept Presumptive Eligibility applications via phone. Use of the Utah Clicks on-line eligibility application system was promoted. This system allows women to fill out on application via the internet and send it to their local provider. Training of local

health department staff and other Presumptive Eligibility staff continued.

The prenatal care subcommittee of the Perinatal Task Force disseminated a listing of low cost or sliding fee scale clinics and providers in the state. The list was disseminated through the Baby Your Baby hotline, the 211 referral network, Medicaid Eligibility offices, and is displayed on the RHP website.

The RHP worked with partners at the University of Utah to develop the "Menstrual Cycle Knowledge Quiz". The quiz was placed on the RHP website and was geared towards educating women about their menstrual cycles and when they were most likely to become pregnant if they were not using contraception.

It was planned to analyze 2004 Utah PRAMS data to see if timing of Medicaid coverage affects prenatal care entry, this project was not completed in the reporting period. PRAMS data was examined to look at women's reasons for late prenatal care entry, with most women indicating that insurance issues and provider scheduling being the most commonly cited reasons.

RHP staff worked with the March of Dimes Teddy Bear Den to promote their activities among UDOH partners and encourage enrollment among eligible women. The Teddy Bear Den rewards enrolled women for positive health practices during pregnancy, first trimester entry being one.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued to take BYB applications via telephone and on-line.		X		
2. Produced and disseminated a list of low cost prenatal care providers and clinics in the state.		X		
3. Collaborated with CASH program on promoting early prenatal care through the prenatal to five home visiting programs.				X
4. Continued to contract with Salt Lake Community Health Centers, Inc. to provide funds for prenatal care services for women with no insurance.				X
5. Developed the “Menstrual Cycle Knowledge Quiz” and published it to the RHP website.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In FY2008, the Division plans to continue its collaboration with the Child Adolescent and School Health Program and local health department staff on its prenatal to five home visiting program to promote dissemination of information to participating families regarding the importance of early prenatal care.

Baby Your Baby activities will include new ads celebrating 20 years of helping moms and babies that will continue to include the message about early and continuous prenatal care. The program will also implement a Native American Outreach campaign, which will include tribal radio, tribal newspapers, posters, and a Native American focused pregnancy keepsake.

The Division will continue its contract with Salt Lake Community Health Centers, Inc. to provide

funds for prenatal care services for women without third party payers.

The BYB program will continue to accept Presumptive Eligibility applications via phone. It will also continue to facilitate use of the UtahClicks on-line eligibility application system. Training of staff at Presumptive Eligibility sites will continue.

The 2004-2005 Utah PRAMS data will be analyzed to see if timing of Medicaid coverage affects prenatal care entry.

RHP staff will continue its work with the March of Dimes Teddy Bear Den to promote their activities among UDOH partners and encourage enrollment among eligible women. The Teddy Bear Den rewards enrolled women for positive practices during pregnancy, first trimester entry among the positive practices.

c. Plan for the Coming Year

Vital Records 2006 data show that first trimester entry increased slightly from 78.8% to 79.0%. PRAMS data continue to indicate that lack of insurance is the most frequent reason cited by mothers for late entry into care.

In FY2009, the Division, led by Child Adolescent and School Health program, will continue to work with local health departments to promote the importance of prenatal care to families participating in the Prenatal to 5 home visiting program.

Baby Your Baby will continue to air PSAs that include messages about early and continuous prenatal care and financial assistance. The PSAs will run in both English and Spanish. Baby Your Baby will also revamp its website to be more interactive with visitors.

The Division will continue its contract with Salt Lake Community Health Centers, Inc. to provide funds for prenatal care services for women without third party payers.

The BYB program will continue to accept Presumptive Eligibility applications via phone. It will also continue to facilitate use of the UtahClicks on-line eligibility application system. The RHP will work on promoting the UtahClicks application to providers via an article in a Medicaid Information Bulletin that goes out to all Medicaid enrolled providers.

RHP staff will continue its work with the March of Dimes Teddy Bear Den to promote their activities among UDOH partners and encourage enrollment among eligible women. The Teddy Bear Den rewards enrolled women for positive practices during pregnancy, first trimester entry among the positive practices.

The RHP will work on promoting preconception health and planning for pregnancy. The RHP in conjunction with Perinatal Taskforce partners has developed and tested Reproductive Life Plan tools for teens and adult women. These documents will be downloadable in PDF format from the RHP website. We will also print a limited number of copies for dissemination at free pregnancy testing centers.

D. State Performance Measures

State Performance Measure 1: *The percent of women of reproductive age (18-44) who are uninsured.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				14	17.2
Annual Indicator		14.8	15.3	16.1	16.1
Numerator		74729	78617	98370	98370
Denominator		505610	513839	609150	609150
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	16	15	14	13	12

Notes - 2007
Numerator: The proportion of women with no insurance calculated using the data from the Utah Health Status Survey 2006.
Denominator: IBIS Population estimates

Notes - 2006
Numerator: The proportion of women with no insurance calculated using the data from the Utah Health Status Survey 2006.
Denominator: IBIS Population estimates

Notes - 2005
Numerator: The proportion of women with no insurance calculated using the data from the Utah Health Status Survey 2005.
Denominator: IBIS Population estimates

a. Last Year's Accomplishments
The performance measure was not achieved. The Performance Objective was 17.2% and the Annual Indicator was 16.2%. According to Utah's Health Status Survey, approximately 98,370 Utah women of reproductive age reported being uninsured during 2006.

The Reproductive Health Program (RHP), with its internal and external partners, has continued to work towards development and submission of an 1115 Research and Demonstration Waiver to the Centers for Medicare/Medicaid (CMS) to expand Medicaid coverage of women who lose coverage within 60 days following a pregnancy. Work has been ongoing for the past several years to determine whether implementation of the Waiver can meet the budget neutrality requirement that CMS requires for its adoption. It is projected that over 10,000 women per year would have the opportunity to obtain coverage for family planning and other reproductive health care services for an additional two years following their pregnancy should the waiver be implemented. One significant barrier to adoption of the Waiver is that Utah legislative approval must be obtained prior to submission to CMS, which may be problematic due to ongoing growth of Medicaid budgets. While we believe the Waiver would ultimately save the state money in the long run with reduction in closely spaced pregnancies and unintended pregnancies as well as healthier outcomes for the mother and infant, the political environment may be unfriendly to this initiative. The Maternal Child Health Bureau has gained support this year from the Executive Director of the Department and has been meeting with the Department's Health Care Finance Division Director (state Medicaid agency) as he will be responsible for defending the proposal to the Utah Legislature. It is hoped that the Bureau will have the proposal ready for the 2009 Utah Legislative session.

The Reproductive Health Program has worked to increase enrollment into Medicaid for pregnant women who qualify for presumptive eligibility (PE). An innovative online electronic application system, "Utah Clicks", was implemented during 2005 throughout the state to facilitate application

to numerous services available for Utah families, including PE. During 2006 there were 3,223 PE application submitted through Utah Clicks, during 2007 the number increased to 4,414 applications.

The Reproductive Health Program, in conjunction with partners from the Perinatal Taskforce, a diverse group of stakeholders in perinatal health, compiled and reviewed Utah Health Status Survey (HSS) data on uninsured women of reproductive age and found that women were more likely to be uninsured if they had lower levels of education, were Hispanic, were employed less than full time, had lower incomes, lived in rural areas, or were unmarried. These stakeholders also found that the following were cited as reasons women gave for lack of insurance: cannot afford insurance (62%), employer does not offer insurance (34%), lost job (28%), don't need/don't want insurance (22%), lost eligibility (19%), employed part time (17%), and insurance company refused to cover (11%). These data will help to target futures interventions.

The Reproductive Health Program, in conjunction with the Department's Center for Multicultural Health (CMH) compiled a press release targeting Hispanic women of reproductive age with messages regarding the importance of preventive health care and potential resources for insurance coverage for Utahns. The Director of the CMH was interviewed by a popular radio station and listeners were referred to websites with information on the Primary Care Network (PCN) and Utah's Premium Partnership for Health Insurance (UPP). The PCN is a health plan offered by the Utah Department of Health that covers services administered by a primary care provider. Utah's Premium Partnership for Health Insurance (UPP) helps make health insurance more affordable for working individuals and families who do not currently have health insurance by helping to pay monthly health insurance premiums through an individuals employer's health insurance plan.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued development of an 1115 Research and Demonstration Waiver to extend Family Planning benefits to reproductive aged women				X
2. Promoted Utah Clicks on-line application system to encourage enrollment into presumptive eligibility for prenatal Medicaid				X
3. Completed analysis and review of Health Status Survey data on uninsured Utah women of reproductive age to better target interventions				X
4. Compiled press release with Center for Multicultural Health targeting Hispanic women of reproductive age with messages about the importance of preventive health care and resources for the uninsured			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Reproductive Health Program (RHP), with its internal and external partners, will continue to work towards development and submission of an 1115 Research and Demonstration Waiver to the Centers for Medicare/Medicaid (CMS) to expand Medicaid coverage of women who lose coverage within 60 days following a pregnancy. Work has been ongoing for the past several

years to determine whether implementation of the waiver can meet the budget neutrality requirement that CMS requires for its adoption.

In addition, the RHP will continue work to increase enrollment into Medicaid for pregnant women who qualify for presumptive eligibility (PE) through promotion of the Baby Your Baby (BYB) Program and the online electronic application system, "Utah Clicks". The BYB program runs a prominent media campaign through our local CBS affiliate which encourages pregnant women to enroll in presumptive eligibility for Medicaid. The BYB hotline is available during normal business hours to refer callers in need to low cost prenatal care to providers throughout the state and assist them in enrolling in PE for Medicaid.

c. Plan for the Coming Year

The Reproductive Health Program (RHP) will continue work toward gaining approval for an 1115 Research and Demonstration Waiver for Family Planning Services. The goal is to have a proposal developed to present to during the 2009 Utah Legislative session in February. Because state general funds will be required for implementation of the program during the start up years, legislative approval is necessary. The Utah Chapter of the March of Dimes (MOD) is very interested in helping to advocate for the Waiver. The RHP will partner with MOD to develop educational materials for legislators to aid in their educational efforts.

The RHP will also partner with the Utah Chapter of the March of Dimes to provide information on increasing the minimum federal poverty level (FPL) at which women can qualify for prenatal Medicaid during the 2009 Utah Legislative session. Utah is currently one of only a handful of states that continues to maintain income eligibility at 133% of the FPL, Centers for Medicaid and Medicare's lowest allowable level, to qualify for prenatal Medicaid coverage. Utah state legislative approval would be required to increase the income eligibility level in order to increase the number of women who can qualify for prenatal Medicaid. The RHP will once again partner with MOD to develop educational materials for legislators to aid in their efforts.

The RHP will continue to promote the Primary Care Network (PCN) and Utah's Premium Partnership for Health Insurance (UPP) among women of reproductive age through advertisement on RHP's website, health fairs and available media opportunities.

The Reproductive Health Program will continue work to increase enrollment into Medicaid for pregnant women who qualify for presumptive eligibility (PE) by promoting the Utah Clicks online electronic application system through advertisement on the program's website, health fairs and available media opportunities.

Lastly, the RHP will continue to monitor the rate of Utah women of reproductive age who are uninsured and partner with advocates for healthcare reform to assure that this important target group is included in the reform agenda.

State Performance Measure 2: *The proportion of pregnancies that result in a live birth that are intended.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	66	66	66.4	68.7	67.1
Annual Indicator	66.4	68.6	66.1	65.8	65.8
Numerator	33099	34748	34053	35187	35187

Denominator	49834	50653	51517	53475	53475
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	65.9	66	66.1	66.2	66.3

Notes - 2007
Numerator projected from PRAMS data (2006). Denominator obtained from Utah Vital Records (2006).

Notes - 2006
PRAMS data projected from 2006 births.

Notes - 2005
PRAMS data projected from 2005 births.

a. Last Year's Accomplishments
The performance measure was not achieved. The performance Objective was 67.1% of live births that were intended and the Annual Indicator was 65.8% .

During FY07 the Reproductive Health Program (RHP) partnered with the Utah Public Health Association (UPHA) and Institute of Reproductive Health of Georgetown University to present a breakout session to 16 attendees at the Utah Public Health Association's (UPHA) annual conference in April 2007 on two natural family planning methods: the Standard Days Method(r) (CycleBeads™) and the TwoDay Method((r). To increase consumer access to these methods, consenting attendees' contact information was placed on the website of a Utah-based natural family planning agency as providers of the Standard Days(r) and TwoDay(r) methods. Additionally, willing attendees' names have been placed on an e-mail list to be contacted with further information by RHP.

The RHP developed in English and Spanish a pamphlet entitled "Natural Family Planning-It's Not Your Mother's Rhythm Method" which was made available in both print and via the program's website: www.health.utah.gov/rhp. Information on lactational amenorrhea ("I Just Had a Baby. How Long Before I Can Get Pregnant?"; "I Breastfeed My Baby. Does that Act as Birth Control?" and "Birth Control for Breastfeeding Mothers") was also developed and made available in both print form and via the RHP website. All of these pamphlets are available in English and Spanish.

Information on methods of natural family planning has also been the focus of displays at several health fairs and professional meetings including the Utah Childbirth Educators Conference, the Utah Perinatal Association Annual Conference and the UPHA Conference. Bookmarks in English and Spanish previously developed by a Perinatal Taskforce Subcommittee focusing on preparing and planning for pregnancy entitled: "Before You Get Pregnant" and "Recipe for a Healthy Pregnancy" continue to be distributed at health fairs and through local health departments. Another previously developed pamphlet on low cost family planning resources in Utah was distributed via health fairs, local health departments and via the RHP website. A link to information on the various types of birth control is available on the RHP website. Both the print and website information are available in English and Spanish.

Utilizing PRAMS data, information on the impact of unintended pregnancy was presented to state WIC personnel. Additionally, a PRAMS newsletter, Births from Unintended Pregnancies and Contraceptive Use in Utah, was developed, placed on the RHP website and distributed to over 500 obstetricians/gynecologists, family practice physicians and certified nurse midwives throughout the state. During 2006, WIC added a question to the participant intake form for pregnant women on the intendedness of their pregnancies.

Rather than providing a risk assessment tool for use at pregnancy test sites, the RHP determined

it to be more beneficial to develop a self-assessment reproductive life plan tool providing information on preparing for parenthood to be distributed via print and on its website. The first tool, in English and Spanish, targets teens and is available on the RHP website ("You're a Busy Teen"). Another subcommittee of the Perinatal Taskforce on preconception health care has developed a reproductive life plan tool targeting women in their twenties.

Seven of Utah's twelve local health departments offer low cost family planning services on site; one provides education and referral to local private providers; and two provide subsidized family planning services through private providers. Emergency contraception is available onsite at four local health departments and five refer women requesting EC to private providers. All local health departments require written consent by the parent or guardian to provide family planning services to unmarried minors per state law. Planned Parenthood Association of Utah is the Title X provider of family planning services throughout Utah. Their clinics do not require parental consent for family planning services to be provided to unmarried minors per federal law.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. In collaboration with UPHA and Georgetown University's Reproductive Health Institute, provided an in-service on two methods of natural family planning to health care professionals				X
2. Developed pamphlet on methods of natural family planning				X
3. Distributed information on family planning via print, Internet, conferences and health fairs			X	
4. Presented information on the impact of unintended pregnancy to WIC personnel				X
5. Developed and distributed statewide to health care providers a PRAMS Perspectives on unintended pregnancy				X
6. Developed, printed and place on the Internet a reproductive life plan tool targeting teens			X	
7.				
8.				
9.				
10.				

b. Current Activities

The Reproductive Health Program (RHP) is monitoring PRAMS data to follow trends and demographics of women experiencing unintended pregnancies. Contact is being maintained with trainees in the Standard Days(r) and TwoDay(r). Methods of natural family planning to disseminate information on additional trainings and reimbursement issues. Materials are being developed and published on the RHP website to educate women about the risk of pregnancy without use of contraception and to increase awareness of the fertility cycle. A reproductive life tool for women in their twenties is being developed and a grant written to fund printing and distribution of that tool along with a brochure with information on methods of family planning. Efforts are continuing to promote an 1115 waiver to increase Medicaid coverage for family planning services beyond the current 60 days following delivery through the second year postpartum. Distribution of information on the availability of low cost family planning services throughout Utah along with information on natural family planning continues via print, Internet and conference and health fair displays.

c. Plan for the Coming Year

During FY09 the Reproductive Health Program (RHP) will continue to review PRAMS data to monitor the proportion and demographics of women experiencing unintended pregnancies in Utah. The RHP will continue to seek appropriate avenues to present information on natural family planning and fertility awareness to increase the number of providers aware of and comfortable in discussing modern natural family planning options with clients. Potential interventions to accomplish this goal may be articles in the Utah American College of Obstetricians and Gynecologists newsletter, collaboration with hospital provider networks, Medicaid contracted health plan providers and in-services for appropriate audiences. Collaboration with a Wasatch Front community health center with a large population of Hispanic women will be attempted in an effort to extend awareness of and access to natural family planning services. Work will continue with grass roots 'promatora' groups to provide train the trainer sessions on natural family planning options along with information on other family planning resources available in Utah. Efforts to submit an 1115 waiver to extend Medicaid coverage from 60 days postpartum to two years will continue. The RHP will also continue to disseminate information on fertility awareness, natural family planning and other methods of contraception via print, Internet and conference and health fair displays.

State Performance Measure 3: *The percent of women who are at a normal weight prior to pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				56	56.5
Annual Indicator		56.9	56.3	55.9	55.9
Numerator		28800	28995	29898	29898
Denominator		50653	51517	53475	53475
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	56	56.3	56.6	56.9	57.2

Notes - 2007
Office of Vital Records and Statistics. UDOH 2006

Notes - 2006
Office of Vital Records and Statistics. UDOH 2006

Notes - 2005
Office of Vital Records and Statistics. UDOH 2005

a. Last Year's Accomplishments
The performance measure was not achieved. The Performance Objective was 56.5% and the Annual Indicator was 55.9%.

Utah Vital Records data indicate that the percentage of women who were at a normal Body Mass Index (BMI) prior to pregnancy continues to decline. In 2006, only 55.9% of women were at a normal BMI (a decrease of 0.6% from the previous year), 4.6% were considered underweight, and the remaining 39.5% were either overweight or obese.

To increase the percentage of women with a healthy weight prior to pregnancy, the RHP implemented a variety strategies to increase awareness among women of childbearing ages and health care providers on the association between poor pregnancy outcomes and abnormal weight prior to pregnancy.

The RHP collaborated with the National Association of Chronic Disease Directors Women's Health Council to facilitate use of Utah PRAMS data regarding preconceptional obesity. This collaboration will allow the program to identify additional areas of study as well as interventions that chronic disease programs have used to prevent or combat obesity. These interventions can then be applied to reproductive-aged women. Utah PRAMS staff developed a poster to promote the use of PRAMS by state Chronic Disease programs and displayed it at the National PRAMS conference.

The RHP continued to work with Department obesity efforts to make sure that women of childbearing age are included in prevention plans. Staff members from the RHP and WIC were invited to join the Department's Healthy Weight Workgroup, a group charged with coordinating obesity activities in the department.

The RHP worked with Vital Records staff to reduce the number of birth certificates with missing height and weight data. In 2004, 3.5% of birth certificates were missing a variable to calculate body mass index.

The RHP, in conjunction with partners at the Salt Lake Valley Health Department, was awarded one of eight grants to participate in the Healthy Weight in Women Action Learning Collaborative through AMCHP and CityMatCH. Staff traveled to Atlanta, Georgia in December 2006 for the initial meeting where team building and project design was facilitated. The team attended a second on-site grant meeting in June here in Salt Lake City. At that meeting, project plans continued to be developed and logic models and evaluation plans were designed. Utah's team planned to conduct focus groups with overweight and obese women enrolled in the Salt Lake Valley WIC program to determine barriers to healthy eating and exercise.

In June of 2007, the Centers of Excellence in Women's Health in Utah published a supplement to the Utah's Health: An Annual Review publication titled "Women's Health in Utah". The supplement included two page "snapshots" of women's health issues. Staff from the RHP authored two snapshots on obesity for the publication: "Obesity in Women" and "Obesity and Pregnancy".

The RHP planned to print and disseminate educational materials explaining what body mass index is, why it is important for women to maintain a healthy weight in their reproductive years, and how weight affects pregnancy. This did not happen during the reporting period and was moved to planned activities for FY09.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Worked with the National Association of Chronic Disease Directors to encourage collaboration between MCH and Chronic Disease programs.				X
2. Joined the UDOH’s Health Weight Workgroup as a standing member.				X
3. Worked with Vital Records to reduce missing information on birth certificates.				X
4. Awarded a Healthy Weight in Women Action Learning Collaborative grant from AMCHP and CityMATCH and began work on project				X
5. Published two “snapshots” on obesity among Utah women in “Women’s Health in Utah” special supplement.				X

6.				
7.				
8.				
9.				
10.				

b. Current Activities
The RHP continues to work with Department obesity efforts to make sure that women of childbearing age are included in obesity prevention plans and interventions.

The RHP continues to work with Vital Records staff to reduce the number of birth certificates with missing height and weight data. In 2005, 3.9% of birth certificates were missing a variable to calculate body mass index, an increase of 0.4% from last year. MCH staff trained hospital clerks to ensure that data for the birth records is complete
Staff from the RHP continued to participate in the Healthy Weight for Women Action Learning Collaborative. Members of the UDOH/Salt Lake Valley team conducted focus groups with overweight and obese women enrolled in WIC. Four focus groups were conducted in English and Spanish to gather information about barriers to healthy eating and exercise. Key informant interviews were conducted with WIC staff to identify barriers to counseling women who were overweight or obese. An intervention program was identified and planning for implementation began.

The Healthy Weight subgroup of the Perinatal Task Force developed and disseminated materials on healthy weight loss after delivery. This information is geared toward helping postpartum women achieve a healthy BMI with reasonable expectations.

A presentation on obesity and pregnancy was presented at the University of Utah's Siciliano Forum on obesity. Data on pre-pregnancy obesity in Utah was presented as well as its impacts on pregnancy.

c. Plan for the Coming Year
The RHP plans to print and disseminate educational materials explaining what body mass index is, why it is important for women to maintain a healthy weight in their reproductive years, and how weight affects pregnancy. These materials will be disseminated via the RHP website and at health fairs.

The Healthy Weight in Women Action Learning Collaborative team plans to implement the "My Bright Future" materials in clinics staffed by certified nurse midwives from the University of Utah. The My Bright Future materials will be given at family planning and postpartum checks and will encourage women to achieve a healthy pre/interconception weight by adopting healthy eating and exercise behaviors. The Utah project will participate in a national evaluation of the My Bright Future materials.

The RHP will continue work with Department obesity efforts to make sure that women of childbearing age are included in obesity prevention plans and interventions. The department's obesity efforts will also work to continue healthy preconception health messages in media and print including: healthy weight, nutrition, and fitness.

The UDOH applied for CDC funding for obesity prevention. Utah's application included use of new PRAMS questions on healthy weight for evaluation and includes activities on breastfeeding promotion. If awarded, staff in the MCH bureau will participate in these efforts.

Utah added new questions on prepregnancy weight and physical activity to the new PRAMS Phase VI survey. Data collection on the new questions will begin with the January 2009 births.

The WIC program will implement a new postpartum course on healthy lifestyles titled "Returning to your prepregnancy weight". This course will help women with information on postpartum eating and exercise that will facilitate healthy weight loss. This course will be especially beneficial to women who may be pregnant again in the future, helping them enter their next pregnancy at a healthy weight.

The Utah WIC Program will be training all WIC health professionals on 2 components of the USDA policy entitled, VENA, during the statewide WIC Conference scheduled for September 2008. This full day interactive training will be designed to enhance WIC professionals' skills in "Critical Thinking" and "Rapport Building" when conducting nutrition assessment interviews. The overall purpose of this VENA training will be to move toward individualized, participant centered interviews which are more culturally appropriate and sensitive to participants' needs. This approach should be particularly beneficial for counseling women on weight issues which can be very difficult for WIC staff and participants to discuss.

State Performance Measure 4: *The percent of pregnant women with appropriate weight gain who deliver live born infants.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				33.9	34.1
Annual Indicator		33.7	33.2	33.0	33.0
Numerator		17069	17119	17639	17639
Denominator		50653	51517	53475	53475
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	34.3	34.5	34.7	34.9	35.1

Notes - 2007
Office of Vital Records and Statistics. UDOH 2006

Notes - 2006
Office of Vital Records and Statistics. UDOH 2006

Notes - 2005
Office of Vital Records and Statistics. UDOH 2005

a. Last Year's Accomplishments
The performance measure was not achieved. The Performance Objective was 34.1% and the Annual Indicator was 33.0%.

Vital Records data for 2006 indicate that 33.0% of women gained an appropriate amount of weight, 14.2% gained too little and 49.0% gained too much weight. Data also show that women at risk for putting on too much weight during pregnancy were overweight before the pregnancy, as defined by Institute of Medicine guidelines. Efforts to increase the proportion of women with appropriate weight gain will be closely related with appropriate prepregnancy weight (SPM 3) interventions.

The RHP program analyzed Vital Records and PRAMS data to identify which women are at the highest risk for either too much or not enough weight during pregnancy. Pregnancy outcomes for women with excessive weight gain were analyzed, with the finding that women with excessive

weight gain were at significantly higher risks of labor abnormality and cesarean section.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Analyzed PRAMS and Vital Records to identify women at the highest risk for inappropriate weight gain.				X
2. Collaborated with the Utah WIC program to support its goal of increasing the percent of pregnant women achieving ideal weight gain.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Two brochures were developed by the WIC program on inadequate and excessive pregnancy weight gain, which were distributed in WIC clinics and posted on the RHP website. BMI specific pregnancy weight gain charts and grids were developed and posted on the Baby Your Baby website.

The RHP successfully lobbied Medicaid to increase reimbursement to registered dieticians for counseling pregnant women who have weight issues. Seven hours of nutritional counseling are part of covered enhanced services for prenatal Medicaid enrollees who are at nutritional risk. A fact sheet on pregnancy weight gain was disseminated to registered dieticians across the state. The mailing encouraged dieticians to enroll as a Medicaid provider as prenatal Medicaid covers nutritional counseling. This information was displayed at the Utah Perinatal Association conference.

Information on excessive pregnancy weight gain was published in the UDOH fact sheet "Health Status Update", a publication distributed to the public and healthcare providers statewide. Information in this fact sheet resulted in a TV news piece and an article in the Salt Lake Tribune.

The RHP continued to collaborate with the Utah WIC Program to support its ongoing goal of increasing the percent of pregnant women achieving healthy weight gain during pregnancy.

An article on obesity and pregnancy weight gain was accepted for publication in "Utah's Health", a publication from the University of Utah. The journal will be published in May 2008.

c. Plan for the Coming Year

Efforts to increase the proportion of women with appropriate weight gain will be closely related with appropriate prepregnancy weight (SPM3) interventions.

After mailing the fact sheet on pregnancy weight gain, along with information on nutrition counseling availability for women on Medicaid to all prenatal care providers in the state, the RHP will track utilization of nutrition counseling by Medicaid participants. The RHP will continue to work with dieticians interested in providing counseling services, as well as maintaining a dietician

referral list for providers wishing to refer a Medicaid participant into nutrition counseling. The RHP plans to look at Medicaid claims data to see if utilization of nutritional counseling increases and to determine if counseling utilization impacts pregnancy weight gain among women utilizing this service.

The RHP and BYB programs will continue to educate women and health care providers on use of the BMI specific pregnancy weight gain charts. The number of downloads of the charts will be tracked.

The RHP will develop and disseminate educational materials for women explaining what appropriate pregnancy weight gain is and how weight gain affects pregnancy. These materials will be disseminated at health fairs and on the RHP website.

Utah added new questions on pregnancy weight gain to the new PRAMS Phase VI survey. Data collection on the new questions will begin with the January 2009 births.

State Performance Measure 5: *The proportion of women who deliver a live born infant reporting postpartum depression who seek help from a doctor, nurse or other health care worker.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				40	35
Annual Indicator		39.5	34.6	38.6	38.6
Numerator		2894	2233	2754	2754
Denominator		7327	6459	7134	7134
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	39	39.5	40	40.5	41

Notes - 2007
PRAMS data 2006
The questions used for this performance measure are as follows:
*Questions:
Since your new baby was born, how often have you felt down, depressed or hopeless? Always, Often, Sometimes, Rarely, Never

Since your new baby was born, how often have you had little interest or little pleasure in doing things? Always, Often, Sometimes, Rarely, Never

The number of women delivering a live infant who answer Always or Often to either question are counted as having reported postpartum depression which is the denominator.

Since your new baby was born, did you seek help for depression from a doctor, nurse or other health care worker?

Notes - 2006
PRAMS data 2006
The questions used for this performance measure are as follows:
*Questions:
Since your new baby was born, how often have you felt down, depressed or hopeless? Always, Often, Sometimes, Rarely, Never

Since your new baby was born, how often have you had little interest or little pleasure in doing

things? Always, Often, Sometimes, Rarely, Never

The number of women delivering a live infant who answer Always or Often to either question are counted as having reported postpartum depression which is the denominator.

Since your new baby was born, did you seek help for depression from a doctor, nurse or other health care worker?

Notes - 2005
PRAMS data 2005
The questions used for this performance measure are as follows:
*Questions:
Since your new baby was born, how often have you felt down, depressed or hopeless? Always, Often, Sometimes, Rarely, Never

Since your new baby was born, how often have you had little interest or little pleasure in doing things? Always, Often, Sometimes, Rarely, Never

The number of women delivering a live infant who answer Always or Often to either question are counted as having reported postpartum depression which is the denominator.

Since your new baby was born, did you seek help for depression from a doctor, nurse or other health care worker?

a. Last Year's Accomplishments
The performance measure was achieved. The Performance Objective was 35% and the Annual Indicator was 38.6%.

Postpartum depression (PPD) is a priority issue in Utah. Among Utah PRAMS respondents in 2006, 13.6% reported experiencing PPD. Despite depression being a treatable illness in most cases, only 38.6% of the women who reported depression sought help from a doctor, nurse or other health care worker for their depression.

To raise awareness of postpartum depression the Reproductive Health Program (RHP) continued to disseminate hard copies of two different styles of PPD posters as requested by health professionals. These posters also remained available on the RHP website in both Spanish and English. One of the posters serves as a conversation/evaluation instigator between a woman and her health care provider regarding her depression status. The other poster acts as a PPD educational tool for the general public. Both posters encourage women to talk with their health care provider about depression.

To further increase awareness, a PPD resource list already available in English was translated into Spanish and made accessible via the RHP website for health care providers as well as the general public. Also, 38,000 Baby Your Baby Keepsake books were disseminated in English and Spanish to childbearing women throughout the state. The Keepsake books contain educational material on PPD and help women know the signs and symptoms of PPD.

Data gathered from focus groups held in 2005 with women who self reported PPD were reported at the annual Maternal and Child Health Epidemiology Conference in December of 2006.

RHP program extensively evaluated PPD in Utah by analyzing data collected by the Pregnancy Risk Assessment Monitoring System (PRAMS). The analysis of these data helped identify risk factors for PPD as well as target groups of women who were less likely to seek help for the depression. These findings were presented to public health researchers in early 2007.

The RHP program had planned to disseminate a PRAMS Perspectives Newsletter on PPD to

health care providers; however, this objective was put on hold as staff members decided to submit the research mentioned above to a peer reviewed journal. Currently staff members are responding to editors' comments and revising the manuscript for publication.

The Child Adolescent and School Health (CASH) Program recognizes the importance of maternal depression and its impact on early childhood development. CASH collaborated with community leaders to provide training on maternal depression at an Early Head Start Program in Utah County. Also the CASH program sponsored two national speakers to come to Utah and speak on early childhood mental health which included information regarding the association between childhood mental health and maternal depression and the importance of screening for maternal depression. Two workshops were held; one at the Critical Issues Conference and the other was part of the Healthy Marriage Conference. Attendees included mental health providers, Head Start staff, child care staff and some academics. The trainings were well received.

Additional trainings to health care providers on screening and treating PPD were not carried out because a grant application submitted to the Aetna Foundation to fund this project was not awarded.

The RHP program intended to collaborate with Valley Mental Health, a community mental health center, to capitalize on efforts, strategies and support pertaining to PPD; however this was not accomplished as of yet, but remains an important strategy to carry out in the future.

RHP staff members attended a mental health outreach meeting sponsored by the National Alliance on Mental Illness Utah (NAMI Utah) in the hopes of creating a partnership. Currently their organization does not have any programs specifically geared toward PPD, which provides an even greater need to follow up with NAMI to create a shared plan of action.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. To raise awareness of postpartum depression the Reproductive Health Program (RHP) continued to disseminate hard copies of educational and screening posters (in English and Spanish) to health professionals.			X	
2. A PPD resource list already available in English was translated into Spanish and made accessible via the RHP website for health care providers as well as the general public.			X	
3. 38,000 Baby Your Baby Keepsake books were disseminated in English and Spanish to childbearing women throughout the state. The Keepsake books contain educational material on PPD and help women know the signs and symptoms of PPD.			X	
4. Data gathered from focus groups held in 2005 with women who self reported PPD were reported at the annual Maternal and Child Health National Conference in December of 2006.				X
5. The RHP program analyzed PPD data from the Pregnancy Risk Assessment Monitoring System (PRAMS). The purpose was to identify differences between women who seek help for PPD and those who don't. Findings were presented to public health researchers.				X
6. The RHP program submitted research on PPD to a peer reviewed journal				X
7. The Child and Adolescent School Health (CASH) program coordinated training on maternal depression and how it impacts				X

children at a variety of conferences. Attendees included mental health, and child development professionals.				
8.				
9.				
10.				

b. Current Activities

Postpartum depression (PPD) continues to be a priority issue in Utah. The RHP will raise awareness among health care providers in Utah by disseminating findings from the PRAMS in relation to the risk factors of women who are less likely to seek help for PPD. These findings, as well as information regarding screening tools and referral options will be distributed through a variety of methods including reports, posters and oral presentations.

The RHP will collaborate with Valley Mental Health and the National Alliance on Mental Illness to capitalize on efforts, strategies and support pertaining to PPD. As well, the RHP will continue to work in partnership with the Baby Your Baby and WeeCare programs to take advantage of the timely opportunity to raise awareness of PPD among participants, and offer referrals as needed.

The RHP will continue to raise awareness of PPD and its effects on family functioning by educating the public via the RHP website, Medicaid health program representatives, posters and other social marketing strategies.

The RHP plans to distribute posters targeting women who may be suffering from PPD as well as their family members. The message of the posters endorses proactive behavior by encouraging women to talk to their health care provider about PPD.

The Child Adolescent and School Health Program continues to look for opportunities to promote the importance of screening for maternal depression and understanding its impact on early childhood development.

c. Plan for the Coming Year

The Reproductive Health Program (RHP) and the Child Adolescent and School Health Program continue to recognize postpartum depression (PPD) as a significant public health concern that needs intervention. RHP remains committed to addressing the need of increasing awareness of PPD and providing information including referral options to the general public, childbearing women and health care providers.

One of the major themes that came from focus groups held with women who self reported PPD was the need for more PPD information to be emphasized in childbirth education classes. To respond to this request, RHP will assess whether childbirth educators incorporate PPD information in their teaching curriculum. Further, RHP will provide Utah specific data on PPD from the Pregnancy Risk Assessment Monitoring System (PRAMS) along with PPD resources to enhance teaching materials for childbirth educators.

RHP will raise awareness of PPD among childbearing women as well as their husbands/partners by collaborating with perinatal education coordinators to ensure that postpartum discharge packets include information on PPD. In addition, RHP will continue to partner with Baby Your Baby in distributing Keepsake books in Spanish and English throughout the state. The Keepsake book contains information regarding the signs and symptoms of PPD and encourages women to talk to their health care provider. Most recipients of the Keepsake book are eligible for prenatal Medicaid, a group which is at higher risk of experiencing PPD, thus the information is pertinent to this population.

Women who are eligible for prenatal Medicaid coverage lose coverage six weeks postpartum

which may affect their ability to pay for mental health services. Because these women are at higher risk for PPD, RHP will work with State Medicaid staff members to include information on PPD in a "termination of coverage" letter sent to postpartum women to encourage women who have symptoms to visit their health care provider before they lose Medicaid coverage.

The WeeCare program, a component of RHP , will continue to take advantage of the opportunity to raise awareness of PPD, screen for prenatal depression and offer referrals as needed to participants during prenatal case management activities. The WeeCare program will also institute a postpartum contact with participants to assess circumstances and provide resources and referrals pertaining to PPD as applicable.

RHP will provide a fact sheet for Valley Mental Health, a community health center, on PPD prevalence in Utah, screening tools and resources available.

The Child Adolescent and School Health Program staff will continue its work with pediatric providers on the importance of screening mothers for depression as it relates to early childhood development. Presentations will be made to providers on the impact of depression for young children.

State Performance Measure 6: *The percent of children who are at risk of overweight and overweight.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				24	22.5
Annual Indicator			24.0	22.5	22.5
Numerator			1020	968	968
Denominator			4250	4310	4310
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	22.5	21.5	21.5	21	21

Notes - 2007
2006 Elementary Student Height/Weight Survey.
Data are based on a statewide weighted sample of schools in which 1st, 3rd and 5th grade students were screened for height and weight in 2006.

Notes - 2006
2006 Elementary Student Height/Weight Survey.
Data are based on a statewide weighted sample of schools in which 1st, 3rd and 5th grade students were screened for height and weight in 2006.

Notes - 2005
Data are based on a statewide sample of schools in which 1st, 3rd and 5th grade students were screened for height and weight in 2005.

a. Last Year's Accomplishments
The performance measure was achieved. The Performance Objective was 22.5 and the Annual Indicator was 22.5.

The Heart Disease and Stroke Prevention Program (HDSPP) developed and released a report summarizing height and weight data collected from a sample of 1st, 3rd, and 5th graders in Utah.

HDSSP continued the implementation and expansion of the Gold Medal Schools program in additional elementary schools. This expansion was made possible by the receipt of an Intermountain Healthcare grant in 2005. The Gold Medal Schools Program increases opportunities for students to eat healthfully, be active and stay tobacco free. Plans for a pilot project to expand the Gold Medal Schools program into middle schools were developed.

Staff participated on the 5-A-Day Association of Utah, and supported the implementation of the annual Kids' 5-A-Day recipe contest. Additionally, staff supported the implementation of a community garden project in Salt Lake and Weber Counties funded through a National Governor's Association "Healthy States" grant. Ten garden projects were launched or enhanced as a result of the funding.

Division of Community and Family Health Services staff participated in Governor Jon Huntsman's Kick-Off to Promote Healthy Weight. The Kick-Off was intended to form partnerships to achieve the strategies and outcomes identified in the Utah Blueprint to Promote Healthy Weight for Children, Youth, and Adults.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Summarized and developed report on height and weight data from a sample of 1st, 3rd, and 5th graders in Utah.				X
2. Expanded Gold Medal Schools to additional elementary schools.			X	
3. Implemented community gardens project in two counties.			X	
4. Participated in launching the Utah Blueprint to Promote Healthy Weight for Children, Youth, and Adults.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Division of Community and Family Health Services supports efforts to collect data to measure the prevalence of "at risk of overweight" and "overweight" children, grades 1, 3 and 5. The Heart Disease and Stroke Prevention Program (HDSPP) and partners will collect the height /weight data every other year. Data collection began in 2002 and will occur in 2008 and 2010.

The Healthy Weight Workgroup (HWW) and HDSPP continue to seek resources to expand the Gold Medal Schools Program to more elementary and middle schools. Possible resources will be sought from the Utah Legislature and CDC. The Program increases opportunities for students to eat healthy, be active, and stay tobacco free. This year, HDSPP will launch Power-Up, an expansion of the Gold Medal Schools program into middle schools, with a pilot test in four schools. WIC Program staff is involved in efforts to address the issue of at risk for overweight and overweight among children enrolled in WIC.

A NGA Healthy Kids Healthy America Program grant was received. NGA funds will be used to enroll every elementary school in the Davis County School District in the Gold Medals Schools Program.

The Division supports the implementation of the Utah Blueprint to Promote Healthy Weight for

Children, Youth, and Adults. The Blueprint offers a comprehensive, statewide obesity prevention agenda emphasizing policy and environmental changes that promote healthier choices among Utah's children and families in a variety of settings.

c. Plan for the Coming Year

The Division of Community and Family Health Services will implement a coordinated effort to collect data to measure the prevalence of at risk of overweight and overweight children in Utah, promote healthy nutrition, and promote physical activity. WIC will monitor children enrolled in WIC relative to those at risk for overweight and overweight.

The Division's HWW will serve as the coordinating group for conducting height and weight measurements in schools. The purposes of this data collection effort are to track growth patterns among Utah's children and provide data that will assist with planning for and evaluating programs. The HDSPP will lead efforts to analyze height and weight data gathered from approximately 7,900 first, third, and fifth graders in 2008. The program will use these data to determine the prevalence of at risk for overweight and overweight children. The HDSPP will continue to lead prevention efforts through its Gold Medal School initiative, which sets criteria and provides funding to encourage schools to address changes in physical activity, nutrition, and tobacco policies in order to create a healthier school environment. Gold Medal Schools will continue to be expanded to additional elementary and middle schools, and resources will be sought to further support this expansion.

Seven programs will continue to serve on the HWW and be involved in coordinated efforts in FY 2009 including the Heart Disease and Stroke Prevention, WIC, Child Adolescent and School Health, Children with Special Health Care Needs, Diabetes Prevention and Control, Check Your Health, and Baby Your Baby Programs. These programs will address environmental and social issues. In collaboration with other state agencies and community organizations, the programs will coordinate efforts to provide safer routes to schools, prevent child abuse, provide media messages and outreach materials on nutrition and physical activity, address diabetes and weight management issues through provider education, and explore other data sources for assessing the weight of additional and special populations.

HWW will support the Utah Fruits & Veggies-More Matters(r) Association to promote increased consumption of fruits and vegetables. Additionally, HWW will support the "Unplug ‘n Play" campaign, designed to raise awareness of the need to decrease screen time for children to less than two hours per day and to encourage active alternatives. The "Walk in the Park" initiative to encourage physical activity by promoting visits to Utah's state parks will be supported.

WIC staff will assist the healthy weight project by tracking the percent of children enrolled in WIC who are at risk of overweight or overweight. These data will be helpful in the development of strategies to address the issue.

The Division will continue to support the implementation of Tipping the Scales Toward a Healthier Population: The Utah Blueprint to Promote Healthy Weight for Children, Youth, and Adults.

State Performance Measure 7: *The percent of youth during the last 12 months who feel so sad or hopeless almost every day for two weeks or more in a row that they stopped doing usual activities.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007

Annual Performance Objective				28.2	28
Annual Indicator			28.2	28.2	25.9
Numerator			434	434	499
Denominator			1540	1540	1926
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	25.9	26	26	27	27

Notes - 2007
2007 YRBS

Notes - 2006
2005 YRBS

a. Last Year's Accomplishments
The performance measure was achieved. The Performance Objective was 28.2 and the Annual Indicator was 25.9.

The Children's Mental Health Promotion Specialist coordinated the Utah Youth Suicide Prevention Work Group until early spring 2007 at which time the group was subsumed by the State Suicide Prevention Council. Since that time the UDOH has participated in the development of a statewide suicide prevention plan in collaboration with the Division of Substance Abuse and Mental Health and other partners. Other plans related to suicide prevention are included in the narrative for the National Performance Measure 16.

Consultation was provided to the Child Fatality Review Committee including review of child deaths to ensure that siblings exposed to domestic violence and child abuse receive available services. These efforts will help reduce the future mental health problems faced by these children.

The department continued to participate in coordination efforts through the Department of Human Services; including, the Utah Transformation for Children and Adolescent Network (UT-CAN), funded by a federal Substance Abuse and Mental Health Services Administration (SAMHSA) grant, to improve the system of mental health services for children.

UDOH was represented on the Child Abuse and Neglect Council (CAN Council) and the Child Abuse and Prevention Interim Action Committee. Consultation was provided on prevention and treatment efforts for children related to domestic violence, child abuse, child neglect, and other violent crimes.

Mental health providers throughout the state were surveyed on training needs specific to children's mental health. Data were collected and preliminary analysis was completed. The information from the assessment will be used to determine professional training needs to build system capacity to promote healthy mental development and provide the most appropriate level of care to children and youth.

The children's mental health specialist provided consultation to the Title V agency to assess the capacity of the agency to address mental health screening and prevention efforts, and reviewed existing data to determine strategies and priorities for future work.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Completed State Suicide Prevention Plan				X
2. Continued to partner with DSAMH on UT CAN project				X
3. Conducted Professional Mental Health Provider Training Needs Assessment				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Children's Mental Health Promotion Specialist along with the Title V Director represents the Utah Department of Health on the Suicide Prevention Council. The council provides coordination of outreach efforts to promote suicide prevention.

The Specialist provides consultation on prevention and treatment efforts for children related to abuse through participation in; the Child Fatality Review Committee, Child Abuse and Neglect Council and the Child Abuse Interim Action Committee. The Title V Director and mental health specialist are involved in the Governor's Family and Child Cabinet Council and Early Childhood Commission.

Collaboration efforts with the Department of Human Services UT CAN project continue. The primary goal of UT CAN is to improve the system of mental health services for children.

The professional mental health provider training needs assessment is being used to determine professional training needs to build system capacity to promote healthy mental development and provide the most appropriate level of care to children and youth. The department is taking a lead in sponsoring national experts to come to Utah and present on topics related to children's mental health.

The children's mental health specialist provides consultation to the Title V agency to address mental health screening and prevention efforts, identify and coordinate prevention and screening efforts and review of existing data to determine strategies and priorities for future work.

c. Plan for the Coming Year

The Children's Mental Health Promotion Specialist will continue to participate on the Utah Suicide Prevention Council by attending meetings and providing consultation as needed. The specialist will be the UDOH lead on youth suicide prevention efforts. The Violence and Injury Prevention Program (VIPP) will continue to provide data collection and analysis.

Participation on the Child Fatality Review Committee will continue with a specific goal to provide consultation in child death reviews and ensure that siblings exposed to domestic violence and child abuse receive available services. These efforts will help reduce the future mental health problems faced by these children.

The Children's Mental Health Promotion Specialist will participate in mental health, substance abuse, domestic violence, child abuse, and suicide prevention conference planning. She will provide information from the mental health provider training needs assessment to conference planners to insure that mental health providers are offered specialized training opportunities for which they have expressed a need. These opportunities will assist in building the capacity of the mental health system to address the screening, and treatment needs of children, youth and their

families. Specific conferences will include: Generations in adult mental health and substance abuse treatment, Critical Issues in Child and Adolescent Mental Health, the Children's Justice Symposium and Domestic Violence Conference, The Utah Child Abuse Prevention Conference and the University of Utah Summer Institute.

Coordination efforts through the Department of Human Services including, the Utah Transformation for Children and Adolescent Network (UT-CAN) will continue. These efforts are specific to improving the mental health care of all Utah children and adolescents.

The UDOH will participate in the Child Abuse and Neglect Council (CAN Council) and the Child Abuse and Prevention Interim Action Committee (CAPIAC), and provide consultation on prevention and treatment efforts for children and adolescents related to domestic violence, child abuse, child neglect, and other violent crimes.

The Title V agency continues to assess its capacity to address mental health screening and prevention efforts. The Title V agency will convene meetings to identify and coordinate prevention and screening effort of various programs. The Specialist will review existing data to determine strategies and priorities for future work. The capacity for enhancing efforts, beginning new efforts, and collecting data will be explored.

State Performance Measure 8: *The percent of children six through nine years of age enrolled in Medicaid receiving a dental visit in the past year.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	44	45	48	49	49.5
Annual Indicator	45.2	47.2	48.8	48.6	51.2
Numerator	11231	12772	14127	13889	14920
Denominator	24863	27088	28943	28596	29135
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	51	52	53	54	55

Notes - 2007
The data are from Medicaid CMS 416 for FFY07.

Notes - 2006
The data are from Medicaid CMS 416 for FFY06.

Notes - 2005
The data are from Medicaid CMS 416 for FFY05.

a. Last Year's Accomplishments
The performance measure was achieved. The Performance Objective was 50% and the Annual Indicator was 51.2%.

During FY07, the Oral Health Program (OHP) collaborated with the Utah Oral Health Coalition in the development and implementation of a public awareness campaign emphasizing the benefits of early and regular dental visits. Efforts to update oral health education materials/curriculum which are used in elementary schools continued.

OHP collaborated with staff in the UDOH Division of Health Care Financing (Medicaid) to expand current EPSDT/CHEC outreach programs to promote dental health care visits. Through these

expanded efforts, outreach workers provided a higher level of care coordination for children needing dental services. The CHEC dental case management system was expanded into all local health departments. CHEC outreach staff are responsible for: 1) conducting outreach to encourage use of preventive and follow-up services; 2) educating children and parents about CHEC benefits and the importance of keeping appointments; 3) working with parents to help reduce barriers to accessing care such as transportation, childcare, language, etc.; 4) serving as liaisons with dental offices to recruit and encouraging dentists to become Medicaid providers.

In addition, Division of Health Care Financing staff worked with private dental office staff on billing and other issues that have arisen. OHP worked closely with the Utah Dental Association and the Utah Oral Health Coalition in efforts to increase the number of dentists willing to see Medicaid patients in order to increase utilization of oral health care services.

It is anticipated that two HRSA grants will have an impact on increasing dental visits for Medicaid enrolled children. The first assisted local health departments in identifying an oral heath contact person and forming an oral health coalition to increase awareness and improve access to oral heath care. The second was a statewide media campaign to educate parents and caregivers of the importance of the first dental visit by age one. These initiatives will help increase the publics' understanding of the need for early and regular dental visits.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Supported the Utah Oral Health Coalition in educating the medical and dental provider community in an awareness campaign emphasizing the benefits of early and regular dental visits.				X
2. Collaborated with Health Care Financing in enhancement of the CHEC Dental Case Management Project				X
3. Worked with Utah Dental Association Access Committee in advocating and promoting early childhood caries prevention and intervention programs, and the promotion of increased participation from dentists willing to treat Medicaid patients.				X
4. Publicized the oral health curriculum which has been developed by the American Dental Association for school grades 1-8.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Oral Health Program (OHP) is using data from the Medicaid 416 Report to analyze dental utilization trends over the past 5 years. This will help in identifying counties and local health departments which may need additional technical assistance to address access to dental care for children.

OHP is working closely with the Utah Oral Health Coalition to emphasize the importance of dental care as part of prenatal care and the benefits of early and regular dental visits.

OHP is closely working with the "Sealant for Smiles Program". In addition to providing dental

sealants for first, second and sixth grade children in Title I schools, the program also assists in referring children for needed dental services. With the newly announced addition of Dental Select as its fiscal agent, Sealant for Smiles has expanded into Summit, Tooele and Davis Counties.

OHP continues to work with Medicaid staff in training pediatricians and other non-dental health care providers in performing oral health risk assessments and fluoride varnish applications for children as an optional procedure during EPSDT/CHEC well child exams.

OHP is working closely with the Utah Dental Association and the Utah Oral Health Coalition in efforts to increase the number of dentists willing to see Medicaid patients in order to increase utilization of oral health care services by identifying and eliminating barriers.

c. Plan for the Coming Year

The Oral Health Program (OHP) will continue to work closely with the Utah Oral Health Coalition to improve access to dental services and in the development of public awareness campaigns. We will continue to emphasize the importance of dental care as part of prenatal care and the benefits of early and regular dental visits. The oral health education material and curriculum developed by the American Dental Association for grades 1-8 will be publicized and posted on the OHP website.

OHP will continue working with Dental Select's "Sealant for Smiles Program". In addition to providing dental sealants for first, second, and sixth grade children in Title I schools in the Salt Lake County area, the program will continue to assist in referring children for needed dental services. Sealant For Smiles is planning to expand beyond Summit, Tooele and Davis Counties in the coming year.

OHP will continue to collaborate with staff in Medicaid to expand current CHEC outreach programs and promote the CHEC dental case management system. In addition, the OHP will work with Medicaid staff in training pediatricians and other non-dental health care providers in performing oral health risk assessments and fluoride varnish applications for children as an optional procedure during CHEC well child exams.

OHP will also continue to work closely with the Utah Dental Association and the Utah Oral Health Coalition in efforts to increase the number of dentists willing to see Medicaid patients in order to increase utilization of oral health care services by identifying and eliminating barriers.

OHP is in the process of trending utilization data from the Medicaid 416 report for the past 5 years. This will help in identifying counties and local health departments which may need additional technical assistance to address access to dental care for children. The OHP will look for opportunities for funding that will promote better access to dental care, especially for underserved populations.

State Performance Measure 9: *The percent of children with special health care needs in the rural areas of the state receiving direct clinical services through the state CSHCN program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	12	12.5	13	12	12
Annual Indicator	12.9	13.4	11.9	11.5	11.1
Numerator	2583	2742	2493	2403	2371
Denominator	20035	20502	20871	20821	21362

Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	12	12	12	12.5	13

Notes - 2007
Numerator: The number of children served in the rural area based on the Mega West billing system.

Denominator: Estimated proportion of CSHCN children in the rural areas based on SLAITS 2005, 11.0% estimate.

Notes - 2006
Numerator: The number of children served in the rural area based on the Mega West billing system. Denominator: Estimated proportion of CSHCN children in the rural areas based on SLAITS 2001, 11.2%

a. Last Year's Accomplishments
The performance measure was not achieved. The Performance Objective was 12 and the Annual Indicator was 11.1.

Flat or decreasing State and Federal funding and growth in rural populations have made it difficult to continue to provide the same level of service in rural communities as previously done. However, the Bureau of Children with Special Health Care Needs (CSHCN) continued its contractual agreements with local health departments to provide clinics at eight different sites throughout the state. There was a reduction of one rural site due the combining of two adjacent clinics. The contracts provided for RN nurse care coordinators and clerical support staff to schedule clinics, manage care coordination services, arrange tests, collect reports and maintain and manage patient charts. Administration and management responsibilities of the Developmental Consultative Services (DCS) program contracts were assigned to one manager instead of the two in previous years, This change has led to better consistency and ease of coordination of the rural clinics. This manager provided ongoing training and support in the areas of care coordination, patient and chart management, community and Telehealth staffing procedures, and workload management. CSHCN continued to provide ongoing support and training in regard to client database software, as well as billing programs used by the local sites to manage scheduling and patient information, in addition to chart tracking and management procedures and protocols. A contractual agreement with the University of Utah Department of Pediatrics was enhanced to provide consistent pediatric evaluative services for these clinics as well.

With a single administrative manager, CSHCN was able to streamline collaboration and integration with the statewide Medical Home effort and provide close contact and coordination with local primary care medical home providers surrounding optimal care for children. CSHCN continued orientation and training regarding the itinerant clinic processes, as needed, with new local health department staff as well as community care providers. These community providers were also integrated into clinic staffing, if requested, to facilitate greater care coordination. Contact and coordination were also established and supported between the rural clinics and pertinent CSHCN programs often involved the special populations served by clinics, which included the Hearing, Speech and Vision Services; the Fostering Healthy Children Program and the Baby Watch Early Intervention Program.

CSHCN continued its provision of long-distance clinical health care and community staffing using Telehealth videoconferencing technology in place through the University of Utah Telehealth Network (UTN), thus, enhancing and supplementing services to rural children with special needs. Collaboration with UTN in an effort to explore 3rd party reimbursement was initiated as well, leading to on-going investigation of possible reimbursement options for this type of services.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued contractual agreements to provide clinics at eight different rural sites	X			
2. RN and office support provided clinic coordination, scheduling, management, chart maintenance, and follow-up for each clinic	X			
3. CSHCN consolidated and provided administration of the clinics through one program located in Salt Lake [Developmental Consultative Services (DCS)]	X			
4. CSHCN continued support and training for all outlying staff covering care coordination, patient and chart management, community and Telehealth staffing procedures and general clinic management				X
5. CSHCN continued to support and assist local clinics in coordination with the statewide Medical Home effort, other pertinent CSHCN programs, and care management efforts with local primary care providers				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The CSHCN Bureau is continuing its efforts to provide optimal care and services to rural children with special health care needs through specialty itinerant clinics and Telehealth technology. Exploration of increased tele-health reimbursement has been initiated.

The Bureau of CSHCN continues to contract with local health departments to conduct itinerant clinics in eight sites across the state. CSHCN will continue to evaluate the level of need, and explore less costly entities to contract with at each site.

Administration and management of all clinics now is facilitated by one manager, providing for better continuity and coordination of clinical services. CSHCN provides ongoing consultation, training and support on care coordination for contract staff. CSHCN supports the databases used by each site to schedule clinics, collect patient data, chart tracking and maintenance.

CSHCN strives to promote and assist in the integration of local rural clinic activities into the statewide Medical Home effort, and will work closely with local primary care medical home providers to coordinate the care and access to resources for children. Additionally, rural clinic staff collaborate with other CSHCN staff in rural Utah, including the staff from the Fostering Healthy Children, Hearing, Speech and Vision Services and Baby Watch Early Intervention programs. An ongoing Quality Improvement process, involving chart reviews, training and care management strategies has continued.

c. Plan for the Coming Year

While Federal and State funding remains flat, and rural Utah continues to have a shortage of pediatric sub-specialists, but also an increase in population growth in some areas. The Bureau of CSHCN will continue to contract with local health departments and other entities to conduct

itinerant clinics in eight sites across the state. CSHCN will continue to evaluate the need to maintain and bolster those sites with increasing populations, and to consider consolidation of clinic sites that only serve a small population of children. Administration and management of all clinics will be facilitated through one manager, providing for improved continuity and coordination of clinical services. Through the contracts, local registered nurse care coordinators and clerical staff will schedule and conduct clinics, provide care coordination services, arrange tests, collect reports and maintain medical charts. CSHCN will provide ongoing consultation and support on care coordination issues to contract staff along with training in these areas. CSHCN will support the Access software database used by each site to schedule clinics, collect patient data, chart tracking and maintenance, providing staff assistance and consultation as needed. Information and training on resources and clinical processes will be provided.

CSHCN will promote and assist in the integration of local rural clinic activities into the statewide Medical Home effort, and will work closely with local primary care medical home providers to coordinate the care and access to resources for children. Additionally, rural nurses will be encouraged to collaborate, and assist in doing so with other CSHCN staff in rural Utah, including the staff from the Fostering Healthy Children Program and the Hearing, Speech and Vision Services Program and Baby Watch Early Intervention programs. These efforts will provide opportunities for community providers to join and interact with CSHCN clinical staff regarding specific care management issues. An ongoing Quality Improvement process will be continued as well.

The CSHCN Bureau will continue its efforts to provide optimal care and services to rural children with special health care needs through Telehealth technology. These activities will supplement services to rural children with special needs using video-conference technology currently in place through the University of Utah Telehealth Network and also State and local health department sites. On-going advocacy for, and exploration of, reimbursement opportunities will continue through a joint effort by these agencies.

E. Health Status Indicators

/2009/ #01A. The percent of live births weighing less than 2,500 grams

#01B. The percent of live singleton births weighing less than 2,500 grams

a) Provide information on the state's residents

Low birth weight is a high risk factor impacting the health of the infant. We know that LBW infants are at higher risk for complications after birth, such as respiratory, metabolic and nutrition conditions that may require longer hospitalizations and possibly impact the child's future health and development. This indicator provides important information about the outcomes of pregnancy that are not positive. We use the data from this indicator to identify and monitor trends related to the population of women giving birth to LBW infants, such as entry into prenatal care, health care coverage before pregnancy, preconception visits, especially for women with chronic diseases that may contribute to a low birth weight infant, information provided during pregnancy, in order to target interventions for prevention.

b) Assist in directing public health efforts

Data on this indicator are reviewed annually to identify trends of concern, such as increasing rates and high risk populations with rates higher than the state average rate.

Data are then used to develop strategies to address those at highest risk for low birth weight, such as pregnant teens continuing tobacco use throughout their pregnancy. We use the data to ensure that policies and programs are data driven. We have used these data to change the focus of interventions, such as partnering with our Tobacco Prevention and Control Program to disseminate educational and resource materials through agencies that come in contact with pregnant teens. We can look at what we are currently doing to determine if we need to amend the current strategies or develop new ones.

c) Serve as a surveillance or monitoring tool

Tracking the percentage of live births that result in low birth weight (LBW) births enables the Utah Department of Health (UDOH) to assure that we are monitoring trends especially those that are going in the wrong direction, such as this one.

d) Function as an evaluative measure

By tracking this indicator, we can assess how the state is doing in this area. We can use the indicator to compare to national and other state rates as a benchmark, determine to some degree if what we are doing is having an impact on the indicator. We realize that there are many factors that play into the rate of low birth rate, but monitoring trends helps us to evaluate what we are doing and whether we need to amend or change strategies.

#02A. The percent of live births weighing less than 1,500 grams

#02B. The percent of live singleton births weighing less than 1,500 grams.

a) Provide information on the state's residents

Very low birth weight is a significant risk factor impacting the health of the infant. We know that VLBW infants are at much higher risk for complications after birth and that a high percentage of VLBW infants either do not survive or have long term morbidities despite optimal care. We use the data from this indicator to identify characteristics related to the population of women giving birth to VLBW infants, such as health care coverage before pregnancy, preconception visits, especially for women with chronic diseases that may contribute to a very low birth weight infant. We also analyze VLBW data by maternal behavioral risks that may predispose women to deliver a VLBW infant, such as tobacco use or advanced maternal age at first birth.

b) Assist in directing public health efforts

Data on this indicator are reviewed annually to identify trends of concern, such use of infertility treatments for conception so that can use to develop strategies to address. We use the data to ensure that policies and programs are data driven. We have used data to change the focus of interventions, such as educating women of reproductive age about the importance of being at optimal health preconceptionally. We can look at what we are currently doing to determine if we need to amend the current strategies or develop new ones.

c) Serve as a surveillance or monitoring tool

Tracking the percentage of live births that result in very low birth weight (VLBW) births enables the Utah Department of Health (UDOH) to assure that we are monitoring trends especially those that are going in the wrong direction, such as this one.

d) Function as an evaluative measure

By tracking this indicator, we can assess how the state is doing in this area. We can use the indicator to compare to national and other state rates as a benchmark, determine to some degree if what we are doing is having an impact on the indicator. We realize that there are many factors that play into the rate of low birth rate, but monitoring trends helps us to evaluate what we are doing and whether we need to amend or change strategies.

#03A. The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

a) Provide information on the state's residents

Unintentional injuries are the leading cause of death for Utah residents ages 1-14 years. Tracking this HSI provides valuable information to the Utah Department of Health (UDOH) to assess the need for new policies and programs or to evaluate the effectiveness of existing policies and programs. These data are also important for monitoring the state's progress toward achieving the Healthy People 2010 Objective 15-13.

b) Assist in directing public health efforts

Since injuries are a substantial and preventable public health problem in Utah, injury surveillance is one of the most important and basic elements of injury prevention. It helps determine the magnitude of injury mortality, the leading causes of unintentional injury death, and the population groups and behaviors associated with the greatest risk to determine program and prevention priorities.

c) Serve as a surveillance or monitoring tool

The injury prevention program depends on unintentional injury mortality data for program planning and evaluation. Data are relevant for all persons engaged in injury research, prevention, and control activities. The UDOH relies on these data to assess specific needs for injury prevention programs and policies and to monitor their effectiveness. Tracking this HSI provides an ongoing process of monitoring the mortality rate, causes, and circumstances resulting in fatal injuries and then disseminating these data in order to prevent these deaths from occurring.

d) Function as an evaluative measure

This HSI is used for outcome evaluation. The rate determines whether the program met the stated long-term goals of reducing the mortality rate.

#03B. The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among children aged 14 years and younger.

a) Provide information on the state's residents

Motor vehicle crashes are the leading cause of injury death among children aged 14 years and younger in Utah. Tracking this HSI provides valuable information to the UDOH to assess the need for new policies and programs or to evaluate the effectiveness of existing policies and programs. These data are also important for monitoring the state's progress toward achieving the Healthy People 2010 Objective 15-15.

b) Assist in directing public health efforts

Since motor vehicle crash injuries are a substantial and preventable public health problem in Utah, surveillance is one of the most important and basic elements of injury prevention. It helps determine the magnitude of injury mortality, the leading causes of motor vehicle

crash injury death, and the population groups and behaviors associated with the greatest risk to determine prevention priorities. This data are crucial for evaluating the effectiveness of program activities and for identifying problems that need further investigation.

c) Serve as a surveillance or monitoring tool

Injury prevention programs depend on motor vehicle crash injury mortality data for program planning and evaluation. Data are relevant for all persons engaged in injury research, prevention, and control activities. The UDOH relies on these data to assess specific needs for injury prevention programs and policies and to monitor their effectiveness. Tracking this HSI provides an ongoing process of monitoring the mortality rate, causes, and circumstances resulting in motor vehicle crash fatal injuries and then disseminating these data in order to prevent these deaths from occurring.

d) Function as an evaluative measure

This HSI is used for outcome evaluation. The rate determines whether the program met the stated long-term goals of reducing the mortality rate.

#03C. The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

a) Provide information on the state's residents
Motor vehicle crashes are the leading cause of death among youth aged 15 through 24 years in Utah. Tracking this HSI provides valuable information to the UDOH to assess the need for new policies and programs or to evaluate the effectiveness of existing policies and programs. These data are also important for monitoring the state's progress toward achieving the Healthy People 2010 Objective 15-15.

b) Assist in directing public health efforts

Since motor vehicle crash injuries are a substantial and preventable public health problem in Utah, surveillance is one of the most important and basic elements of injury prevention. It helps determine the magnitude of injury mortality, the leading causes of motor vehicle crash injury death, and the population groups and behaviors associated with the greatest risk to determine prevention priorities. These data are crucial for evaluating the effectiveness of program activities and for identifying problems that need further investigation. The Violence and Injury Prevention Program has targeted this HSI as a focus for local health department injury prevention efforts.

c) Serve as a surveillance or monitoring tool

Injury prevention programs depend on motor vehicle crash injury mortality data for program planning and evaluation. Data are relevant for all persons engaged in injury research, prevention, and control activities. The UDOH relies on these data to assess specific needs for injury prevention programs and policies and to monitor their effectiveness. Tracking this HSI provides an ongoing process of monitoring the mortality rate, causes, and circumstances resulting in motor vehicle crash fatal injuries and then disseminating the data in order to prevent these deaths from occurring.

d) Function as an evaluative measure

This HSI is used for outcome evaluation. The rate determines whether the program met the stated long-term goals of reducing the mortality rate.

#04A. The rate per100,000 of all non-fatal injuries among children aged 14 years and younger.

a) Provide information on the state's residents

Surveillance of unintentional injuries resulting in hospitalization provides an important perspective on the public health burden of injury morbidity. Unintentional injuries are often a contributing factor in temporary or permanent disability and poor health. The leading causes of unintentional injury hospitalization in Utah for children aged 14 years and younger are falls, motor vehicle crashes, and struck by or against. Tracking this HSI provides valuable information to the UDOH to assess the need for new policies and programs or to evaluate the effectiveness of existing policies and programs. These data are also important for monitoring the state's progress toward achieving the Healthy People 2010 Objective 15-14.

b) Assist in directing public health efforts

Injuries are a substantial and preventable public health problem in Utah. Injury surveillance is one of the most important and basic elements of injury prevention and control. It helps determine the magnitude of injury morbidity, the leading causes of unintentional injury hospitalization, and the population groups and behaviors associated with the greatest risk to determine prevention priorities. These data are crucial for evaluating the effectiveness of program activities and for identifying problems that need further investigation.

c) Serve as a surveillance or monitoring tool

The injury prevention program depends on unintentional injury morbidity data for program planning and evaluation. Data are relevant for all persons engaged in injury research, prevention, and control activities. The UDOH relies on these data to assess specific needs for injury prevention programs and policies and to monitor their effectiveness. Tracking this HSI provides an ongoing process of monitoring the morbidity rate, causes, and circumstances resulting in non-fatal injuries and then disseminating the data in order to prevent these injuries from occurring.

d) Function as an evaluative measure

This HSI is used for outcome evaluation. The rate determines whether the program met the stated long-term goals of reducing the morbidity rate.

#04B. The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger.

a) Provide information on the state's residents

Injuries from motor vehicle crashes are the second leading cause of injury hospitalization among children aged 14 years and younger in Utah, trailing only falls. Surveillance of motor vehicle crash injuries resulting in hospitalization provides an important perspective on the public health burden of injury morbidity. Motor vehicle crash injuries are often a contributing factor in temporary or permanent disability and poor health. Tracking this HSI provides valuable information to the UDOH to assess the need for new policies and programs or to evaluate the effectiveness of existing policies and programs. These data are also important for monitoring the state's progress toward achieving the Healthy People 2010 Objective 15-17.

b) Assist in directing public health efforts

A greater number of motor vehicle crashes result in increased number of hospitalizations, increasing undue financial burden on the health care system. Motor vehicle crash injuries are more prevalent in adolescence and early adulthood. Motor vehicle crashes are a substantial and preventable public health problem in Utah. Surveillance is one of the most important and basic elements of injury prevention and control. It helps determine the magnitude of injury morbidity, the leading causes of motor vehicle crash injury hospitalization, and the population groups and behaviors associated with the greatest risk to determine prevention priorities. These data are crucial for evaluating the effectiveness of program activities and for identifying problems that need further investigation.

c) Serve as a surveillance or monitoring tool

The injury prevention program depends on motor vehicle crash injury morbidity data for program planning and evaluation. Data are relevant for all persons engaged in injury research, prevention, and control activities. The UDOH relies on these data to assess specific needs for injury prevention programs and policies and to monitor their effectiveness. Tracking this HSI provides an ongoing process of monitoring the morbidity rate, causes, and circumstances resulting in non-fatal injuries and then disseminating the data in order to prevent these injuries from occurring.

d) Function as an evaluative measure

This HSI is used for outcome evaluation. The rate determines whether the program met the stated long-term goals of reducing the morbidity rate.

#04C. The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

a) Provide information on the state's residents

Injuries from motor vehicle crashes are the leading cause of injury hospitalization among youth aged 15 through 24 years in Utah. Surveillance of motor vehicle crash injuries resulting in hospitalization provides an important perspective on the public health burden of injury morbidity. Motor vehicle crash injuries are often a contributing factor in temporary or permanent disability and poor health. Tracking this HSI provides valuable information to the UDOH to assess the need for new policies and programs or to evaluate the effectiveness of existing policies and programs. These data are also important for monitoring the state's progress toward achieving the Healthy People 2010 Objective 15-17.

b) Assist in directing public health efforts

A greater number of motor vehicle crashes result in increased number of hospitalizations, increasing undue financial burden on the health care system. Motor vehicle crash injuries are more prevalent in adolescence and early adulthood, with the highest rates among 16 to 19 year olds. Motor vehicle crashes are a substantial and preventable public health problem in Utah. Surveillance is one of the most important and basic elements of injury prevention and control. It helps determine the magnitude of injury morbidity, the leading causes of motor vehicle crash injury hospitalization, and the population groups and behaviors associated with the greatest risk. These data are fundamental in determining prevention priorities, evaluating the effectiveness of program activities, and identifying problems that need further investigation.

c) Serve as a surveillance or monitoring tool

The injury prevention program depends on motor vehicle crash injury morbidity data for

program planning and evaluation. Data are relevant for all persons engaged in injury research, prevention, and control activities. The UDOH relies on these data to assess specific needs for injury prevention programs and policies and to monitor their effectiveness. Tracking this HSI provides an ongoing process of monitoring the morbidity rate, causes, and circumstances resulting in non-fatal injuries and then disseminating the data in order to prevent these injuries from occurring.

d) Function as an evaluative measure

This HSI is used for outcome evaluation. The rate determines whether the program met the stated long-term goals of reducing the morbidity rate.

#05A. The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.

a) Provide information on the state's residents

Chlamydia can impact a woman's future fertility and has few recognizable symptoms. Utah law restricts information to minors by public agencies, such as the schools, which presents challenges in providing prevention education. This indicator is important for us so that we can determine if the rates and trends are improving and how Utah rates and trends compare with national rates and trends. Preliminary data for 2007 indicate a chlamydia rate of 12.43 per 1,000 females aged 15 through 19 years old. In 2006 the rate was 10.68 per 1,000 females aged 15-19 years old.

b) Assist in directing public health efforts

This indicator assists UDOH programs to monitor trends in rates so that we can evaluate what we are doing to reduce rates to determine if there are other strategies we need to employ to reduce rates. If we see the rates increasing, as demonstrated for 2005, we can review programs and strategies, funding allocations, and so on to determine if what we are doing is effective. MCH staff collaborates with the State STD/HIV/HCV Prevention Program, which is in another Division in the UDOH. Staff participates in joint meetings with outside partners to address the issues related to this sexually transmitted disease. Utah law does restrict what can be taught in public schools about sexuality and safe sex practices other than abstinence.

c) Serve as a surveillance or monitoring tool

This indicator is used as a tool to monitor trends in Utah and also to compare Utah rates and trends with national rates and trends. Though our rates are low compared to the national rates, the trend is Utah is following the national trend of increasing rates.

d) Function as an evaluative measure

The indicator can be used to evaluate what UDOH is doing to make a difference, recognizing that there are many factors that contribute to the rate, of which we have little control. However, reviewing the data does help us determine to a certain degree if we are having some impact on the rates.

#05B. The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

a) Provide information on the state's residents

Chlamydia can impact a woman's future fertility and has few recognizable symptoms. This

indicator is important for us so that we can determine if the rates and trends are improving and how Utah rates and trends compare with national rates and trends. Preliminary data for 2007 indicates a chlamydia rate of 4.98 per 1,000 females aged 20 through 44 years old. In 2006 the rate was 4.53 per 1,000 females aged 20-44 years old.

b) Assist in directing public health efforts

This indicator assists UDOH programs to monitor trends in rates so that we can evaluate what we are doing to reduce rates to determine if there are other strategies we need to employ to reduce rates. If we see the rates increasing, as demonstrated for 2005, we can review programs and strategies, funding allocations, and so on to determine if what we are doing is effective. MCH staff collaborates with the State STD/HIV/HCV Prevention Program, which is in another Division in the UDOH. Staff participates in joint meetings with outside partners to address the issues related to this sexually transmitted disease.

c) Serve as a surveillance or monitoring tool

This indicator is used as a tool to monitor trends in Utah and also to compare Utah rates and trends with national rates and trends. Though our rates are low compared to the national rates, the trend is Utah is following the national trend of increasing rates.

d) Function as an evaluative measure

The indicator can be used to evaluate what UDOH is doing to make a difference, recognizing that there are many factors that contribute to the rate, of which we have little control. However, reviewing the data does help us determine to a certain degree if we are having some impact on the rates. //2009//

F. Other Program Activities

/2009/ In reviewing the outcomes for the National Performance Measures and the State Performance Measures, we achieved 13 National Performance Measures and 5 State Performance Measures. We did not reach the objectives on 5 National Performance Measures and 2 State Performance Measures. This achievement of National and State Performance Measures is an improvement from previous years when we have achieved fewer National and State Performance Measures. We will continue to review the measures we did not achieve to determine how we can improve these measures. //2009//

The State Title V agency is involved in many activities that address the needs of mothers and children in the state. The Division of Community and Family Health Services has established several new programs within the past five years that impact others and children. These include Asthma and Chronic Disease Genomics Programs. Both of these programs will be important to the public health work focused on mothers and children in the state.

The Asthma Program is designed to develop state capacity to address asthma. The Program monitors asthma rates and is concerned about the rise in children reported to have asthma, which in 2004 was 8%, an increase since 2001 with 5% reporting asthma. The Program works with schools to address the health needs of children with asthma. Legislation was passed in 2004 that allows children with asthma to carry inhalers with them in school to use as needed. The change was needed due to state rule that prohibits children from carrying any kind of drug on school property. The Program has developed a school manual that assists school personnel in understanding asthma better and how they can assist a child with asthma at school. The manual can be accessed at

http://health.utah.gov/asthma/schools.html

The Chronic Disease Genomics Program promotes awareness of genomics and how genes can impact the health of the public. The Program provides up-to-date resources on genomics in today's world and information on the importance of family health history in understanding one's own health. http://health.utah.gov/genomics/index.html This program and its work will become even more important as we learn more about genomics and its relationship to health.

In addition, other programs in the Department, such as HIV/AIDS, Heart Disease and Stroke Prevention, and Diabetes Prevention and Control, include Title V staff in their work. Of particular note is the Gold Medal School program. The Gold Medal School (GMS) program makes it possible to provide opportunities for physical activity and healthy nutrition choices in elementary schools at a time when budget cuts and testing requirements overshadow physical activity and nutrition. The Utah Department of Health developed the GMS program in 2001 using the State Office of Education's core curriculum and the Centers for Disease Control's guidelines to address overweight and obesity in elementary schools. Today, it is the most successful program for physical activity and nutrition in the state, reaching more than 75,000 kids in 160 schools! Schools that sign up for GMS are required to meet certain criteria, such as developing policy that implements the State Office of Education's physical activity core curriculum that includes 90 minutes of structured physical activity each week, or establishing a Gold Medal Mile walking program in which each student's goal is to walk a mile each week, setting policy that food is not used by teachers as a reward or punishment, etc. A University student majoring in health nutrition, physical education, or elementary education is assigned to each participating school. Criteria are set for bronze level, silver level and gold level with schools receiving a cash prize that they can use for new PE equipment, nutrition resources or tobacco prevention materials.

The Center for Multicultural Health, created by 2004 Legislation, is working with programs to discuss program needs in outreach to members of different cultures in the state as well as provide appropriate data on subpopulations. The Division houses the Center, which benefits Division programs due to close proximity. The Center Coordinator has interfaced with programs to assess their needs and will be working with them to develop strategies that will increase agency capacity for cultural competence. The Center works with the following populations: Asian, Black/African American, Hispanic/Latino, Native American/Alaska Native, and Pacific Islander/Native Hawaiian. The Center has established work groups for specific health issues of ethnic and minority populations, for example, reduction in infant mortality. tobacco use, cancer prevention and so on. Staff utilize the Center's staff and resources for information on outreach techniques, cultural awareness, information presentation, and so on to assure materials and approaches are appropriate and successful.

The Department released a report on the Health Status by race and ethnicity, which provides a wealth of information on each subpopulation in the state. The report can be accessed at http://health.utah.gov/opha/publications/raceeth05/RaceEth05.htm

/2009/ The Center for Multi-cultural Health is in the process of reporting on a qualitative data process to obtain data on health needs of subpopulations in the state. The Reproductive Health Program was involved in the effort and will have data on reproductive health issues of the Hispanic population. //2009//

In 2001, Legislation was passed to allow a mother not wanting to keep her newborn baby to drop the baby off at a hospital with no questions asked. The Legislation was crafted to help reduce the possibility of infant death due to a mother "discarding" her baby in a dumpster or other places leading to the infant's death. The Adolescent Health Coordinator is working with the sponsor of the bill and representatives of various agencies to develop print materials and resources for the public to promote the "safe haven" option for women who chose not to keep their babies. The campaign kicked off in 2005. The Department will pay for access to a national toll-free 24/7 hotline for anyone in Utah to avail themselves of this service. In May 2006 another press

conference was held to introduce PSAs developed to promote the messages about safe haven through the media.

The Division participates on numerous advisory committees sponsored by other state agencies or private agencies to enable the Title V programs collaborate with vital external partners in their work. Examples include the Child Abuse Prevention Council, Child Care licensing, and so on. In general the state title V agency has exerted concerted effort to increase its collaborative efforts with private providers, professional associations and its agency partners to address the health needs of mothers and children, including those with special health care needs.

As we have developed data capacity, we have expanded our ability to "research" various issues impacting mothers and children in the state. For example, the MCH Staff has looked at weight prior to pregnancy and weight gain in pregnancy to determine its possible impact on pregnancy outcomes; postpartum depression and how women are not screened or listened to when they express concerns about their mental health; prenatal care analysis to determine factors associated with late entry, and so on. Expansion of data capacity has enabled programs to conduct surveys, compile data that are important in identifying a health issue and related factors.

G. Technical Assistance

Utah's Title V Technical Assistance Needs include:

1) Needs Assessment - We are very interested in looking at the process we used for the last needs assessment to see if we repeat that process or utilize another process. Given Utah's size and issues associated with a large rural/frontier state, we are interested in learning what similar states have done for their needs assessment process. We would like to learn about other states' processes, but it is not helpful to hear what a state like California or Texas has done because we are so different in terms of capacity.

2) Uninsured women - An area that we feel particular concern is the proportion of women of childbearing age who are not insured. We have focused a great deal of our statewide efforts on children and while we have a ways to go to improve in this area, we need to acknowledge that women have higher rates of no insurance than the general population. We would like technical assistance on methods to address this problem. When women have no insurance, they are less likely to plan pregnancy, engage in preventive health care, such as family planning or prenatal care. The most common reason women reported late entry into prenatal care was "no money". If we could ensure that more women had insurance, we would see improvement in intended pregnancy, early prenatal care, etc.

3) Mental Health among mothers and children in the state --A significant portion of Utah mothers who deliver a live born infant report feeling moderate to severe depression several months after delivery. Mental health for children and youth in the state is an issue that concerns many working in the field of mental health and substance abuse, as well as those of us in public health. We would request technical assistance to help us determine best practices to promote mental health among families in the state. The state Title V agency is not interested in screening and early recognition of social emotional issues in young children, their mothers (and fathers), and among children of all ages. We are particularly concerned about the early childhood population of children since social emotional problems in the children or their parents may negatively impact their development. We are interested in best practices for children and mothers in this area that we might be able to replicate in Utah.

4) Overweight and Obesity --Given the national trend in overweight and obesity, Utah public health officials are very concerned about the increasing trend in the state. We want to focus our efforts on women of childbearing ages in terms of prepregnancy weight and weight gain during pregnancy. Prepregnancy weight can be considered a proxy for the weight of all women in these

ages and we need to work to ensure that as women prepare for pregnancy they consider their weight along with other possible risk factors, such as medications, chronic health conditions, etc. As women go on to have pregnancies, we want to ensure that they don't continue to keep on unnecessary weight after the pregnancy, compounded by additional pounds with each pregnancy. We would like technical assistance on promotion of healthy weight among women of childbearing ages.

In addition we would like technical assistance on best practices related to healthy weight in children of all ages. We have the Gold Medal School program, which promotes healthy lifestyles, including good nutrition and adequate physical activity in elementary schools. We want to expand the program into secondary schools, which would cover all school aged children and youth in the state. Best practices on how to reach youth on the issues of healthy food and physical activity would be very helpful as we strategize to attack this problem among Utah children.

5) Transition for CYSHCN -we would like assistance with transition issues for CYSHCN. How can we engage adult primary care providers to increase their capacity to address the health, emotional, etc needs of young adults transitioning from pediatric, long-term providers.

6) Cultural Competency - since one of our priorities is ethnic and cultural issues, we would like TA from the National Center for Cultural Competency so that we can better address issues for ethnic and minority populations in our state

V. Budget Narrative

A. Expenditures

Please see notes related to Form 3, Form 4, and Form 5.

/2008/ Please see notes related to Form 3. //2008//

/2009/ Please see notes related to Form 3 and Form 4. //2009//

B. Budget

The Division of Community and Family Health Services (CFHS) is organized to address specific maternal and child health needs through a partnership between State agencies and the private sector to form a coordinated statewide system of health care. CFHS's Block Grant funds are distributed according to the plan of expenditures contained in this application which is based upon a statewide assessment of the health of mothers and children in Utah. Funding reported within this application/annual report is based on the state fiscal year.

The amount of state funds that will be used to support Maternal and Child Health programs in FY08 is shown in the budget documentation of the state application. We assure that the FY89 maintenance of effort level of State funding at a minimum will be maintained in FY08 [sec.505(a)(4)].

For each four federal dollars a minimum of three state dollars is specifically designated as match. CFHS allocates a total of $22,750,850 of state funds appropriated by the Legislature for MCH activities. A total of $10,635,050 is designated as match for the MCH Block Grant federal funds which exceeds the minimum requirement of $5,024,835. The remaining non-designated state funds will be used in matching Title XIX (Medicaid) and combined with other federal and private funding to expand and enhance MCH programs and activities. Programs including Baby Your Baby, Birth Defects, Tobacco Prevention, Fostering Healthy Children, and Baby Watch/Early Intervention, significantly benefit from this use of the state funds. CFHS receives private funding which is used to enhance selected programs or projects such as Baby Your Baby, WEE Care, Cervical Cancer Vaccine and Education, and Gold Medal Schools Obesity Prevention. Local MCH funds reported reflect county, health district, and other local revenue expended to conduct MCH activities and make services available in local communities.

CFHS assures that at a minimum 30% of the Block Grant allocation is designated for programs for Children with Special Health Care Needs and 30% for Preventive and Primary Care for Children. Special consideration was given to the continuation of funding for special projects in effect before August 31, 1981. Consideration was based on past achievements and the assessment of current needs. Title V funding has been allocated to support these activities which were previously funded [sec.505(a)(5)(c)(i)].

CFHS assures that entities, including the Utah Department of Health, that use Title V funds for direct services bill on a sliding fee schedule according to federal income guidelines. This requirement is included in all contracts in which Title V funds are awarded to local health departments and other entities.

CFHS will maintain budget documentation for Block Grant funding/expenditures for reporting, consistent with Section 505(a), and consistent with Section 506(a)(1) for audit purposes. Audits are conducted by the state auditor's office following the federal guidelines applicable to the Block Grant. In addition, the State Health Department maintains an internal audit staff who reviews local health departments for compliance with federal and state requirements and guidelines for contract/fiscal matters.

CFHS will allocate funds under this title fairly among such individuals, areas, and localities identified in the needs assessment as needing maternal and child health services. Funds are distributed largely according to population, although consideration is given to districts with identifiable maternal and child health needs and factors that influence the availability and accessibility of services. These needs are identified in large part by local communities themselves. There are a number of other program-specific advisory groups which have access to funding information for their related programs. These groups provide guidance and support for programs such as Perinatal Task Force, Child Fatality Review, WIC, Newborn Screening, Baby Watch/Early Intervention, and Tobacco Prevention.

The Department negotiates contracts with each of the twelve local health departments encompassing many public health functions, and progress is measured against the achievement of the MCH performance measures. The following MCH activities are included: child health clinics, dental health, family planning, injury prevention, prenatal services, school health, speech and hearing screening, and sudden infant and childhood death counseling. The allocation of funds, i.e., contracts, staff, or other budget categories, to meet the maternal and child health needs of the community is left to the discretion of the local health officer. This places the determination of need and the allocation of funds for specific needs at the source of expertise closest to the community. State staff provide local health departments specific data to assist them in determining community needs. Local health department staff and state staff jointly develop an annual plan to address these needs. Annual reports are required from each local health department to monitor MCH activity and document their achievement in impacting the health status indicators for their local MCH populations.

The Division continues to allocate all available resources (MCH Block Grant funds, state funding, Medicaid, other private and public grants, and local funds) to most effectively address the changing maternal and child health needs throughout the state.

/2009/ The Division of Community and Family Health Services (CFHS) is organized to address specific maternal and child health needs through a partnership between State agencies and the private sector to form a coordinated statewide system of health care. CFHS's Block Grant funds are distributed according to the plan of expenditures contained in this application which is based upon a statewide assessment of the health of mothers and children in Utah. Funding reported within this application/annual report is based on the state fiscal year.

The amount of state funds that will be used to support Maternal and Child Health programs in FY09 is shown in the budget documentation of the state application. We assure that the FY89 maintenance of effort level of State funding at a minimum will be maintained in FY09
[sec.505(a)(4)].

For each four federal dollars a minimum of three state dollars is specifically designated as match. CFHS allocates a total of $25,386,000 of state funds appropriated by the Legislature for MCH activities. A total of $15,267,300 is designated as match for the MCH Block Grant federal funds which exceeds the minimum requirement of $4,902,075. The remaining non-designated state funds will be used in matching Title XIX (Medicaid) and combined with other federal and private funding to expand and enhance MCH programs and activities. Programs including Baby Your Baby, Birth Defects, Tobacco Prevention, Fostering Healthy Children, and Baby Watch/Early Intervention, significantly benefit from this use of the state funds. CFHS receives private funding which is used to enhance selected programs or projects such as Baby Your Baby, WEE Care, Cervical Cancer Vaccine and Education, and Gold Medal Schools Obesity Prevention. Local MCH funds reported reflect county, health district, and other local revenue expended to conduct MCH activities and make services available in local communities.

CFHS assures that at a minimum 30% of the Block Grant allocation is designated for programs for Children with Special Health Care Needs and 30% for Preventive and Primary Care for Children. Special consideration was given to the continuation of funding for special projects in effect before August 31, 1981. Consideration was based on past achievements and the assessment of current needs. Title V funding has been allocated to support these activities which were previously funded [sec.505(a)(5)(c)(i)].

CFHS will maintain budget documentation for Block Grant funding/expenditures for reporting, consistent with Section 505(a), and consistent with Section 506(a)(1) for audit purposes. Audits are conducted by the state auditor's office following the federal guidelines applicable to the Block Grant. In addition, the State Health Department maintains an internal audit staff who reviews local health departments for compliance with federal and state requirements and guidelines for contract/fiscal matters.

CFHS will allocate funds under this title fairly among such individuals, areas, and localities identified in the needs assessment as needing maternal and child health services. Funds are distributed largely according to population, although consideration is given to districts with identifiable maternal and child health needs and factors that influence the availability and accessibility of services. These needs are identified in large part by local communities themselves. The allocation of funds is subject to review by the MCH Advisory Committee. In addition, there are a number of other program-specific advisory groups which have access to funding information for their related programs. These groups provide guidance and support for programs such as Child Fatality Review, WIC, Newborn Screening, Baby Watch/Early Intervention, and Tobacco Prevention.

The Department negotiates contracts with each of the twelve local health departments encompassing many public health functions, and progress is measured against the achievement of the MCH performance measures. The following MCH activities are included: child health clinics, dental health, family planning, injury prevention, prenatal services, school health, speech and hearing screening, and sudden infant and childhood death counseling. The allocation of funds, i.e., contracts, staff, or other budget categories, to meet the maternal and child health needs of the community is left to the discretion of the local health officer. This places the determination of need and the allocation of funds for specific needs at the source of expertise closest to the community. State staff provide local health departments specific data to assist them in determining community needs. Local health department staff and state staff jointly develop an annual plan to address these needs. Annual reports are required from each local health department to monitor MCH activity and document their achievement in impacting the health status indicators for their local MCH populations.

The Division continues to allocate all available resources (MCH Block Grant funds, state funding, Medicaid, other private and public grants, and local funds) to most effectively address the changing maternal and child health needs throughout the state.

//2009//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.